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CONTENTS AND SUBJECT INDEX

The Romance of Medicine. William D. Haggard, M.D., Nashville, Tenn..1611

The Dermatologist-Syphilologist in the United States. J. E. Lane, M.D., New Haven, Conn.....1616

The Treatment of Diabetes Mellitus in Children. A. Graeme Mitchell, M.D., Cincinnati 1620

The Relation of Orthopedics to Personality. Ira S. Wile, M.D., New York 1623

Congenital Dislocation of the Hip: A Clinical Study of Twenty-Nine Cases. Leonard W. Ely, M.D., San Francisco 1627

Value of Chlorin in the Treatment of Colds. Harold S. Diehl, M.D., Minneapolis 1629

CLINICAL NOTES, SUGGESTIONS AND NEW INSTRUMENTS

Epidermoid Cyst of Cervix Uteri. Joseph B. Bacon, M.D., Macomb, Ill. 1632

Facial Palsy Following Scarlet Fever: A Report of Two Cases. Paul Nathaniel Mutschmann, M.D., Calumet, Iowa.....1633

"Cock-Up" Splint. Fred Ellsworth Clow, M.D., Wolfeboro, N. H....1633

A New Scalpel with Interchangeable Blades. Paul B. Magnuson, M.D., Chicago 1634

MEDICAL EDUCATION, REGISTRATION AND HOSPITAL SERVICE

Schools Offering Summer Courses, 1925 1685

EDITORIALS

Some Truths About Alcohol.....1668

Acid Fruits.....1669

Parturition 1669

CURRENT COMMENT

Actinotherapy 1670

Prosecution of Medical Frauds in California 1671

(Subject Index on next page)

PROCEEDINGS OF THE ATLANTIC CITY SESSION

Addresses of Executive Officers..1635

Report of Secretary.....1638

Report of the Board of Trustees..1640

Report of the Judicial Council.....1655

Report of the Council on Medical Education and Hospitals.....1655, 1661

Report of the Council on Scientific Assembly 1660, 1661

Addendum 1661

Address of President-Elect William D. Haggard.....1663

Address of Dr. J. Basil Hall, President of British Medical Association..1665

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Bulletin

In the physical realm, tools have created more wealth in the past half century than the world had accumulated in the previous eighteen centuries. And it is not too much to say that those intellectual tools named *books* have increased the sum of knowledge gathered in the past century to an even greater degree than the increase in physical treasure.—Newell Dwight Hillis in *The Watchman-Examiner*.

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See Page 3

SUBJECT INDEX TO THIS ISSUE

The letters used to explain in which department the matter indexed appears are as follows: The Star (*) indicates an Original Article; "ab," abstract; "E," Editorial; "C," Correspondence; "T," Therapeutics; "MI," Medicolegal; "P," Propaganda for Reform; "ME," Medical Economics.

A. M. A., Atlantic City Session.....1635
Board of Trustees, report.....1640, 1652
Council on Medical Education and Hospitals, report.....1655, 1661
Council on Scientific Assembly, report.....1660, 1661
House of Delegates, address of President Pusey.....1636
House of Delegates, address of Speaker, Dr. Warnshuis.....1635
House of Delegates, minutes.1635, 1661, 1666
Judicial Council, report.....1655
President-Elect William D. Haggard, address.....1663
Secretary, report.....1638
Abdomen, surgery, fate of sutures in..ab-1694
Achylia gastrica, eosinophilia in.....ab-1703
Acid in fruits.....E-1669
Acidosis.....ab-1706
Actinotherapy.....E-1670
Albuminuria during function test.....ab-1706
Alcohol, some truths about.....E-1668
Amputation of leg.....ab-1705
Anemia, Pernicious, and lymphogranulomatosis.....ab-1705
Anesthetics, effect on whole organism..ab-1698
Aneurysm, cardiac.....ab-1700
ruptured, of basilar artery.....ab-1700
Angina Pectoris, false myogenous.....ab-1708
Aortitis, syphilitic.....ab-1690
Appendectomy, sponge passed by bowel (Okla.).....MI-1688
Appendicitis.....ab-1699
mortality of.....ab-1699
Arteries, coronary changes in.....ab-1706
Arteritis simulating Raynaud's disease.ab-1701
Arthritis, muscular atrophy in.....ab-1699
Atherosclerotic vessels, lipoids in.....ab-1705
Bile, entrance into duodenum.....ab-1698
Birth Control, professional attitude on..ab-1708
Blood, cholesterol, and environment....ab-1701
circulation, efficiency index of.....ab-1707
hemograms, use of.....ab-1706
hypertension and guanidin.....ab-1691
hypertension, arterial.....ab-1702
hypotension causes prerenal anuria....ab-1696
pressure, and phenobarbital.....ab-1696
pressure, and sleep.....ab-1691
sugar, and potassium.....ab-1705
uric acid levels.....ab-1695
volume vs. diet and renal lesions....ab-1692
Bloodletting, technic.....ab-1702
Bone cysts and giant-cell tumors.....ab-1708
Book Notices.....1687
Books Received.....Adv. page 28
Brain tumors, localizing.....ab-1698
British Medical Association, address of president.....1665
California, prosecution of medical frauds in.....E-1671
Cancer, experimental, and vitamin A..ab-1699
soot, experimental.....ab-1699
urine in.....ab-1699
Cannula, improved.....C-1684
Carbohydrate metabolism.....ab-1708
cleavage in plants and animals.....ab-1706
Cerebrospinal Fluid, spirochetes in.....ab-1694
Chenopodium, oil of, an anthelmintic...ab-1693
Chickenpox, smallpox and cowpox.....ab-1705
Chlorin treatment of colds.....*1629
Clostridium botulinum, pathogenicity...ab-1695
Colds, chlorin in.....*1629
Colitis, autogenous vaccines in.....ab-1706
Colon, polyposis of.....ab-1698
technic of roentgen enema.....ab-1705
Colostomy, physiologic conditions for...ab-1708
Condylomas, immune treatment.....ab-1704
Correspondence.....1683
Cysticercus, intra-ocular.....1680
Deaths.....1681
Dentin and enamel.....ab-1702
Dermatologist-syphilologist in U. S.....*1616
Diabetes Insipidus.....ab-1706
Diabetes Mellitus in children, treatment..*1620
insulin in.....ab-1700
insulin in, and gain in weight.....ab-1706
Diphtheria antitoxin in normal blood...ab-1699
toxin, antigenic effect.....ab-1700
toxin, units of measurement of.....ab-1700
Diuresis test, simplified.....ab-1708
Dysentery, susceptibility to.....ab-1702
Eclampsia, dietetic prophylaxis.....ab-1707
serum, immunization against.....ab-1702
Edema, novasurol treatment.....ab-1694
Electric current, death by.....ab-1706
Embolectomy.....ab-1708
Empyema, acute, treatment of.....ab-1705
Enamel and dentin.....ab-1702
Encephalitis vaccine, Levaditi's.....ab-1707
Endocarditis, autofiltrate in.....ab-1702
Endocrine fever.....ab-1703
Epidermoid cyst of cervix uteri.....*1632
Epinephrin, intracardiac injection.....ab-1707
injection causes gangrene.....ab-1701
Evidence, expert, in murder trial.....1676
Eye, enucleation of blind eye, damages (Colo.).....MI-1689
Fats, rôle in vital phenomena.....ab-1700
Fever, therapeutic recurrent, fluid exchange in brain in.....ab-1704
Foreign Letters.....1676
Fracture, previous, roentgen-ray evidence of.....1684
Fruits, acid.....E-1669
Gallbladder and pituitary.....ab-1704
cholecystography.....ab-1701
inflammation, causes stomach hemorrhage.....ab-1703
Gangrene from epinephrin injection....ab-1701
Gastrojejunostomy, end-to-end.....ab-1698
Glucose dialysis, and insulin.....ab-1702
Goiter, classification.....ab-1700
Gonococcus culture mediums.....ab-1695
Government Services.....1676
Granuloma, malignant, roentgenotherapy.ab-1708
Grocco's Sign.....ab-1706
Guanidin and high blood pressure.....ab-1691
Hall, J. Basil, address of.....1665
Heart disease, infected tonsils in.....ab-1697
injections of epinephrin into.....ab-1707
insufficiency, causes edema.....ab-1694
murmur, Flint's symptom.....ab-1707
myocardial infarction.....ab-1695
Ta wave of auricle.....ab-1695
Hemoclastic shock.....ab-1695
Hip Joint, congenital dislocation.....*1627
Hospitals, private, liability of (Wis.)...MI-1688
social service in.....1678
Humoral pathology and Virchow.....ab-1704
Hyperthyroidism, iodin.....ab-1706
Immunization with atoxic filtrates.....ab-1706
Infants, atrophy, anoxemic type.....ab-1699
Infections after primary suture.....ab-1706
Insane, chronic otorrhea in.....ab-1697
Insulin, action on glucose dialysis.....ab-1702
Intestines, flora, and lactodextrin.....1684
Jejunum, cancer.....ab-1700
Kidney, cancer, primary.....ab-1698
function test, sodium iodid and thiosulphate.....ab-1706
lesions, and blood volume.....ab-1692
Larynx, tuberculosis.....ab-1694
Leiomyoma cutis.....ab-1693
Leukemia, myeloid, due to irradiation?..ab-1701
Licensure, Pennsylvania protests New Jersey discrimination.....C-1683
prosecution of medical frauds in California.....E-1671
Liver function after hydrochloric acid poisoning.....ab-1706
Lungs, foreign body in.....ab-1705
Lymphogranulomatosis and anemia.....ab-1705
Malaria, latent, quinin in.....ab-1702
quinin-fast lipase in.....ab-1706
tropical comatose.....ab-1705
Malpractice, damages, punitive (N. J.)..MI-1689
Marriages.....1681
Maternal mortality, causes of.....ab-1697
Maternity, state aid for, Germany.....1680
Medical Education, Registration.....1685
Medical Practice Acts, sale of drugs as practice of medicine (Calif.).....MI-1689
Medical Schools, offering summer courses..1685
Medicine, romance of.....*1611
Medicolegal.....1688
Meetings, Coming Meetings.....1690
Menopause, hypertension in.....ab-1703
Metabolism, mineral, rays and protein in.ab-1704
Mitral defects, vertebra tenderness in..ab-1705
Mycosis fungoides vs. lymphosarcoma..ab-1693
Nephritis, kidney decapsulation for....ab-1696
Bright's disease, classification.....ab-1692
Nephropexy.....ab-1707
New and Nonofficial Remedies.....1634
News.....1671
Orchitis in mumps, convalescents' serum prevents.....ab-1701
Orthopedics, relation to personality.....*1623
Osteomalacia in girl aged 17.....ab-1702
Otorrhea, chronic, in insane.....ab-1697
Ovary, disorders, sympathectomy in....ab-1703
Oxyuriasis, treatment.....ab-1705
Ozena, surgical treatment of.....1680
Paralysis, facial, after scarlet fever.....*1633
general, malaria treatment.....ab-1697
Parotitis, contagious.....ab-1701
convalescents' serum prevents.....ab-1701
Parturition.....E-1669
Patella,, congenital anomaly.....ab-1693
resection, in knee affections.....ab-1707
Peptic Ulcer, pathogenesis.....ab-1704
Peritonitis, acute serous.....ab-1706
Petrolatum Agar Emulsions, examination.*1682
Pharynx, lesions.....ab-1693
Pigment cells, 2 types.....ab-1694
Pituitary Extract and gallbladder.....ab-1704
Plague transmitted by tarabagan fleas..ab-1693
Poisons, resistance to, and vagotonic condition.....ab-1702
Pregnancy and heart disease.....ab-1708
effect on cancer.....ab-1707
Presentation, breech, lumbar puncture in child in.....ab-1703
Propaganda for Reform.....1682
Prostate, enlarged, heart in.....ab-1696
Pulse, optic registration of.....ab-1703
Pyloric Stenosis, glucose solution in....ab-1702
Queries and Minor Notes.....1684
Raynaud's Disease, arteritis simulating..ab-1701
Recklinghausen's Disease of skull.....ab-1702
Reflexes, Hering's carotid.....ab-1704
Rickets, treatment of.....ab-1708
Ring Reaction.....1684
Ringworm of scalp.....ab-1693
Roentgen Rays causes leukemia.....ab-1701
Roentgenogram in evidence on deposition (Ala.).....MI-1688
Roentgenologist and practitioner.....ab-1700
Saliva, pH constancy of.....ab-1704
Salts, acid-producing, diuretic action of.ab-1695
Sarcoma cutis of Spiegler.....ab-1693
Scalpel, with interchangeable blades.....*1634
Scarlet Fever, facial palsy after.....*1633
skin tests in.....ab-1701
vaccine treatment.....ab-1703
Schistosomiasis, intestinal, treatment of....1680
Sciatica, epidural injections in.....ab-1706
muscular theory of.....ab-1708
Sleep, effect on blood pressure.....ab-1691
Smallpox and alastrim, serodiagnosis....ab-1702
chickenpox, cowpox and.....ab-1705
vaccination.....ab-1697
Society Proceedings.....1675, 1690
Specialties, regulation, Germany.....1679
Splint, "cock-up".....*1633
State Board Examinations.....1683
Sterilization, surgical, with soda solution, prevents infections.....ab-1705
Stomach, adenomyoma of.....ab-1699
atony of, after Billroth I.....ab-1707
hemorrhage, due to cholecystitis....ab-1703
leather bottle stomach.....ab-1698
secretion and ingested substances.....ab-1702
Strontium, action of.....ab-1705
Sutures, fate of.....ab-1694
Sympathectomy, periarterial, on hypogastric and ovarian arteries.....ab-1703
Syphilis, congenital.....ab-1708
mercurosal in.....ab-1693
sterilizing treatment in.....ab-1703
Syphilologist-dermatologist in U. S.....*1616
Tabes Dorsalis, specific and nonspecific therapy.....1679
Tachycardia, paroxysmal, organic lesions in.....ab-1701
Tendon of Achilles, rupture.....ab-1703
Tendovaginitis, rheumatic.....ab-1705
Tetanus, serotherapy, and chlorform....ab-1701
Tetany in infants.....ab-1704
Thymus and creatin metabolism.....ab-1703
Thyroid, gumma in.....ab-1706
Tissue section, melanin oxidation in....ab-1705
Tonics and Sedatives.....Adv page 22
Tonsils, infected, in cardiac cases.....ab-1697
Trocar, improved.....C-1684
Tuberculosis, phosphorus metabolism in..ab-1695
disability in.....1678
milk supply and, in England.....1677
Tuberculosis, Pulmonary, iodin in.....ab-1703
roentgen-ray diagnosis.....ab-1697
Typhoid, mortality of.....ab-1694
treatment of.....ab-1694
vaccination against.....ab-1694
Ulcers, treatment.....ab-1699
Uncinariasis, diagnosis.....ab-1700
Ureter, calculus in.....ab-1702
calculi, removal by inflation.....ab-1698
Urethritis, gonorrheal, vaccine therapy..ab-1701
Urine; anuria, prerenal.....ab-1696
anuria, postrenal.....ab-1696
Uterus, cancer, effect of pregnancy on..ab-1707
epidermoid cyst of cervix.....*1632
inflammation, electric cauterization in.ab-1698
Vas Deferens, Steinach's operation.....ab-1704
Vein, unusual situation of.....ab-1702
Verruca, immune treatment of.....ab-1704
Vitamin B, rôle in protein and carbohydrate metabolism.....ab-1702
Vivisection, dog's protection bill, England.1677
Whooping Cough, tuberculin treatment..ab-1704
Yellow Fever, anatomy of.....ab-1704

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THE ROMANCE OF MEDICINE*

WILLIAM D. HAGGARD, M.D.

NASHVILLE, TENN.

"Taught by art divine the sage physician eludes the urn, and chains or exiles death."

The story of medicine enthralls the imagination by its infinite charm and arouses admiration for its victories in the battles against disease.

Its romance is so compelling that men cannot be unmoved by its blessings, when they realize with us its splendor. The records of the discoveries of medicine are more fascinating than fiction; their marvelous benefits are as if in response to Jeremiah's lament, "Is there no balm in Gilead, is there no physician there?"

The price of these great benefactions is beyond all the rubies of the world; it can never be computed and it can never be paid. In the Middle Ages the average life of man was twenty-odd years. Now the span has been increased almost threefold. Compute if you can the growth in economic value of a human life extended to this lengthened expectancy and worth an ever-increasing yearly wage. Compute the value given by bestowing these benefits to all the nations of the world. If you can estimate these things, only then will you have totaled the economic wealth contributed to mankind by this incomparable service. And in the precious years that have been added to the span of life, countless days of unhappiness and suffering have been eliminated. Innumerable ills have been parried from the feeble flesh of man. What a glorious thing it is when the piteous procession of men and women beg of you to be allowed to live a little longer on any terms, that you can succor them by the knowledge of Nature's secrets that are your heritage from the studies of the scholars of all times.

Wonderful as the past has been, the last fifty years of medicine has witnessed more achievements of a miraculous character than the five preceding centuries. This is the golden age of medical advancement. Discoveries of transcendent import have trooped on us in bewildering profusion. Allusion to some will suffice to give a glimpse of the glamour by which all are pervaded. The last century gave us ether and chloroform, by which, as Oliver Wendell Holmes said, "the fiercest extremity of suffering was steeped in the waters of oblivion and the deepest furrow in the knotted brow of agony has been smoothed away forever." Antisepsis has revolutionized surgery and made possible the present proud perfection of that most brilliant of all the arts. Mathematically, it has reduced the death rate from all amputations from 65 per cent. in Paris in 1861, to 4.5 per cent. in Pennsylvania today. Among its many almost incredible feats is now recorded a successful effort to cut the shortened cords inside the heart itself, and allow the fettered valves to close again securely. Although the heart is only one inch from the surface of the body, twenty centuries of surgery rolled by before the scalpel could travel that inch.

Medicine is the only profession that is literally and altruistically devoted to professional suicide. It endeavors chiefly, not alone to cure, but to prevent disease, and thus to banish from mankind pain, suffering and ultimate death from maladies of the flesh. But what it cannot prevent it must cure. What it cannot cure it must palliate. Angina pectoris, the merciless, is now being attacked surgically and the heart-pang relieved in certain cases by severing the sympathetic nerves in the neck that transmit the unendurable pain.

The discovery of the germ of tuberculosis, "the Captain of the men of Death," was the beginning of the annihilation of the Great White Plague and is a more important victory for mankind than resulted from the Fifteen Decisive Battles of the World. Already the death toll has been reduced from 160 per hundred thousand in 1910 to 97 per hundred thousand in 1922. But the fact that even today every third minute on the clock's dial marks a death from tuberculosis challenges us to still greater efforts. It is now largely a social problem. As the contagion for the most part comes from the lungs and mouth, we must teach everybody not only to burn expectorations, but to avoid this contagious material in every possible way. We must prevent, rather than be faced by the necessity of attempting later cure.

That the spirochete was the actual cause of syphilis, the great Black Plague, was discovered by Schaudinn in 1905. Miraculously enough, in the next year Ehrlich discovered that his six hundred and sixth experiment with arsenical compounds gave the present arsphenamin, with power to stay its ravages.

A romance in medicine to grip the admiration of the world is the subjugation of typhoid fever. In the Boer War, typhoid destroyed 8,000 British soldiers, while only 7,000 were killed by all the enginery of Mars. In the World War, as a result of antityphoid vaccine, which was given to each of our 4,000,000 American soldiers, and increasing knowledge of sanitation, only 1,083 cases of typhoid fever developed, with only 158 deaths. If the ratio between enlistments and deaths from typhoid in the American Civil War had been maintained in the World War, there would have been some 226,000 cases, with 62,694 deaths. This conquest of typhoid is one of the greatest benisons of modern medicine.

* President's address before the American Medical Association at the Seventy-Sixth Annual Session, Atlantic City, N. J., May, 1925.

Under a picture that was current recently, of a fervent minister, robed and with upraised hand, was the legend "Preaching to beat Hell." We, as ministers of health, must also unceasingly preach—preach pure water, fresh air, sunshine, sanitary environment, plain, wholesome food, exercise and right living—to defeat the powers of darkness and bring the purity of heaven to earth.

Most dramatic among modern victories is the conquest of yellow fever, the scourge of the Spanish Main, "the pestilence that walketh in darkness; . . . the destruction that wasteth at noonday." An epidemic of this in 1793 took the lives of 10,000 people in Philadelphia in three months and kept the Southern states in consternation with the recurring seasons. Its devastation prevented the genius of France from building the Panama Canal across a zone which for four centuries had been called the "white man's grave." The indomitableness of Roosevelt was matched by the genius of Gorgas, the master of yellow fever, who made of the charnel-hole of Panama the healthiest spot on earth. Thus occurred the union of the oceans through the canal.

In the opening year of the twentieth century, Reed, Carroll, Lazear and Agramonte proved, through the peace-time bravery of American soldiers who bared their bodies for the fateful experiments, that a mosquito transmits yellow fever. While experimenting with death-laden *Stegomyia,* one of these army surgeons was bitten on the hand and sacrificed his own life in the consuming passion to save his fellow man. No man hath greater love than this. As Agramonte said of him, "One more name, that of Jesse W. Lazear, was graven upon the portals of immortality." Is it immodest for us in recounting this heroic self-sacrifice to have the pride of guild and to regard proudly the noble deeds of our profession?

In the last decade, many diseases of the heart, kidneys, gallbladder and other organs have been shown to be derived frequently from the foci of infection around the teeth, in the tonsils, in the sinuses of the nose, and in other structures. This great discovery has enabled the physician to administer in many cases the most effective of all treatments, the removal of the cause. Rosenow has taken the infectious material from the vicinity of stone in the kidney and, by implanting it in a cavity drilled in the healthy tooth of a dog, has been able to produce stone in the dog's kidney in 85 per cent. of the cases. By injecting into the veins of a rabbit's ear material taken from an infected appendix, from ulcer of the stomach, and from inflammations associated with gallstones, Rosenow has also been able to reproduce the disease in the organ from which it was obtained. This experimentation seems to show the specificity of certain micro-organisms for regularly attacking the same structures, under definite conditions. We know, for instance, that the agent in infantile paralysis gains access through the nasal cavity and lodges in the anterior horn of the spinal cord. Prevention or even eradication of diseased foci thrice arms the physician of today for the throttling of many insidious diseases or, if they have gained headway, their amelioration or cure.

The discovery of radium by Madame Curie close on the discovery of the roentgen ray by Roentgen in 1896 was not only a triumph in wresting another secret from the physical world, but has furnished a most necromantic weapon for the cure of certain forms of cancer and for its palliation in hopelessly neglected cases.

The use of safe drugs for local injection in rendering surgical operations painless is now like a performance in a world of magic. Antitetanic serum to prevent lockjaw is the king of preventive serums. Practically every battle casualty in France was potentially infected with lockjaw. Every wounded man that came back from the front had A. T. S. (antitetanic serum) pasted on his forehead. The universal use of the serum mercifully prevented the terrors of lockjaw.

The transfusion of blood into the veins of those who from injury or disease are sickened into the whiteness and coldness of death quickly brings back the glow to the cheek and the red-lipped promise of reclaimed life. This boon was made possible by the discovery by Mall, of the four types of blood; the use of an untyped and dissimilar blood-group donor is most dangerous.

We physicians and the whole world are daily debtors to the innumerable instruments of precision, to the blood pressure apparatus, the basal metabolism rate machines, and the newer instruments for administering gases, that render anesthesia almost totally devoid of danger.

What is more astounding than the revelation in the last few decades of the part played in our bodies and lives by the wonder-working ductless glands? They send weird and powerful hormones as chemical messengers to command the functions of the body. The thyroid gland presides over our growth; its absence makes the gnomelike grotesque idiot, the cretin. Administration of the life-giving thyroid extract veritably restores the dead in mind and brings dwarfed bodies back to blooming youth. Compared to these realities, legends of old-time restoration of the dead are but interesting myths.

It seems incredible that the pituitary gland at the base of the brain, weighing only 2 grams, will, when diseased, cause the prodigious growth of a giant, and when its secretion is deficient produce the enormous fat deposit of the pathologically obese.

The greatest romance of the last few years in medicine was the discovery of insulin by Banting. The wizardry of rescuing the diabetic patient by this remarkable discovery is truly a marvel.

Goiter is largely due to a deficiency of iodin in food and water. While it can be successfully removed, with an infinitesimal death rate, it should be prevented in childhood by the administration of iodin in small quantities to children twice a year. These wonder-working ductless glands largely determine personality. Individuality seems, after all, to be largely the product of the chemistry of our bodies.

Passing from the intangible to the practical, we may note that the solution of the pellagra problem seems nearer with the increasing belief that pellagra is a deficiency disease, possibly from a shortage of vitamins, and seems to be caused by faulty protein food mixture and is greatly benefited by fresh meat and milk. These and other contributions of medicine to the relief of humankind are more thrilling to the man of science than all the wars of selfish kings.

I am not an unqualifying eulogist of the profession of medicine; I am but telling the plain, unvarnished truths that constitute the romance of our great calling. Like every sublunary institution, that of medicine is subject to evils, many of them common to it and other professions, and many others pertain to it alone. We

are prone to be overenthusiastic about each new advance; on the other hand, many of us are as unable to evaluate the worth of a fresh discovery as was Joseph Bell (the original of Sherlock Holmes) to recognize the solemn significance of antisepsis, as advocated by Lister, albeit he was his daily colleague in the wards of the Glasgow Infirmary.

It may not be regarded as romantic, and therefore within the realm of this paper, to recall that the cause of typhus fever is the bite of an infected body louse; but when one thinks of the terrifying epidemics on sea and land which have been stamped out by this knowledge and by sanitation, our medical accomplishment rises, not only to the romantic, but to the sublime. Likewise the most fatal of all infections, plague, bubonic and pneumonic, is transmitted to man by the flea that has bitten the infected rat. The extermination of the rat to prevent it and Haffkine's vaccine to cure it is a historic achievement. Rocky Mountain spotted fever has been shown by Ricketts to be transmitted by the wood-tick.

The most threatening cloud of chronic disease in the South, hookworm, has been dissolved by the wand of Aesculapius. Through the labors of physicians and the beneficence of the Rockefeller Institute, the weakened, anemic, shiftless "poor white" has, by the use of thymol, been freed from the parasite. There is yet so much to discover. It requires a vision and endless, patient, animal experimentation. Claude Bernard said that whenever he left his laboratory he put on the cloak of his imagination in order to know where next to look, through experimentation, for Truth. The microbic causes of smallpox, of measles, of mumps, of chickenpox and of the much-dreaded encephalitis (so-called sleeping sickness) are as yet undetected. And many chronic diseases are still eluding an accurate analysis and a cure. Lest we be vainglorious, let us hasten to remember that there is as yet no specific for pneumonia, which, with the other acute respiratory diseases, destroys more lives every day than any other one ailment.

Cancer, the most pitiless of all maladies, is our rebellious and still elusive foe. It has not yielded up its murderous secret. We know all about its life history except the very beginning. It is regularly curable in its first stages, in many cases by surgery, in many by radium, and in others by the roentgen ray; but its bacterial causes, if such there be, still elude the patient investigator. The honor and benefit of this great discovery is more to be desired by the physician than the wealth of Midas, the wisdom of Solomon or the glory of Napoleon.

The fiery serpent that bit the children of Israel when they wandered through the wilderness was possibly the guinea-worm, which enters the body as a water-flea, develops, and ultimately lies coiled under the skin, from 1 to 6 feet in length. It formerly was coaxed out by winding it on a stick little by little each day. Then the zoologist found that it seeks water in which to lay its eggs, and will naively crawl out if the affected leg or arm is simply submerged in water for a few hours.

The mysterious is so simple when revealed by science! And so our learning advances little by little. Each of the myriad of discoveries for the protection of man against his environmental enemies is almost akin in comparative magnitude to the body of a single tiny coral polyp in the great structure to which it contributes. Thus we rear the eternal structure of the Temple of Medicine.

PERIODIC HEALTH EXAMINATION

The real romance of present-day medicine is to prevent or to discover early the degenerative conditions of the great organs, the heart, kidneys, liver and brain. All the saving in life has been in the prevention of infant mortality in the control of contagious diseases. Eternal vigilance of every individual by his physician is the price of lengthened life in the middle aged.

As civilization can be measured by the statistics of public health, so sanitation is an expression of humanitarian impulses coupled with intelligent and expert application of medical knowledge to the community. Preventive medicine has made phenomenal progress in recent years. Particularly is this exemplified in the unsurpassed efficiency of the American army from the point of view of health during the World War. It was the cleanest army the world has ever seen. There were required more than 35,000 of the flower of the American medical profession to make and keep it fit to fight. None but the regular practitioners of medicine were permitted to touch the bodies of the precious soldiers in cantonment or advanced sector; but the noncombatants were constantly attacked at home, as always, by bizarre methods of treatment, so called, of a type which, as Barnum said, the American people love.

Community health is much in advance of the prevention of illness in the individual. Physicians have been so busily occupied in the care of the acutely sick that they may have had little time and have given scant attention to those who are in apparent health. People in great numbers have been amazed, when resting securely in the supposed enjoyment of perfect health, to find that an examination for life insurance revealed some entirely unsuspected malady, such as Bright's disease, diabetes or heart disease, that could and should have been easily detected long before. One third of the people who die from heart disease or Bright's disease die before they are 50 years of age. Even apoplexy shows 15 per cent. of its mortality under 50. These three conditions cause more than one fourth of all deaths. By early detection and eradication of the causes of these fatal lesions, many unnecessary deaths can be prevented.

What does it profit a person to neglect his physical condition and the wonderful mechanism of his body, the temple of his immortal soul? All other machinery is thoroughly overhauled at regular intervals. Boilers are frequently inspected, lest they explode. We all, physicians and laymen, have ignored the tremendous importance of a periodic and thorough physical examination. We have thus neglected our patients and even ourselves. In Shakespeare's Cymbeline, the Bard sagely remarks, "By medicine life may be prolonged, yet death will seize the doctor, too."

Have a thorough physical examination on your birthday! It should be a real survey of a man's physical as well as mental status. Why should not a yearly inventory be made by one's physician of his habits, environments, occupation and dietary? If this plan could become universal, it would be the best postgraduate course in physical diagnosis that our profession as a whole could take.

From the economic side, there could scarcely be a better and closer relation between the physician and his clientele. The actual care and completeness of the

examination would be in such startling contrast to the inadequacy and makeshift examination by the irregular practitioners and cults that it would be an education to patients who are not now privileged to understand really the difference between a competent, regularly graduated high-type physician and the man who without adequate preparation masquerades under the guise of a doctor. The humaneness of the thing would appeal to the patient who needs us to tell him how to keep well. We will utilize our skill in anticipating future disability. We shall be promoting the ever-widening field of preclinical medicine, and shall at last come into our own, because in the interpretation of our findings and the laying down of rules of health and conduct we shall at last be carrying out the original meaning of the word "physician," which is teacher. We must learn to deal with the brutally healthy man who never thinks of anticipating disease and forgets what a tremendously intricate and wonderfully made machine he so wofully neglects. He is very confident, yet his apparently superb stamina sometimes plays him false by throwing him entirely off his guard and making him an easy prey for some insidious disease stealthily to take hold on him. The proverb says, "Honor a physician before thou hast need of him."

It is estimated that the number of cases of sickness in this country in a year is thirteen and a half million, costing the nation a billion dollars. It is astounding to think that there are 225 million days of sickness a year in the United States. If it were possible, by nation-wide effort, to reduce the amount of sickness by 25 per cent., the total economic gain yearly would be around a quarter of a billion dollars. How can one estimate the worth in anguish relieved and death postponed? Prevention runs as a thread of gold through the fabric of medicine. Every time we prevent illness we not only preserve that one individual as a productive force, but also one or two persons who would be required otherwise to care for him. The military maxim that it is better to wound an enemy than to kill him is based on this idea.

The people should be taught that in truth there can no more be different "schools" of medicine than there can be different schools of physics, or of mathematics or astronomy. There is nothing under the sun which is of proved value that has not and will not be used by the profession in the treatment of disease. All of chemistry, of sanitation, of serums, of massage, of treatment by radium, of surgery, and of application of drugs are at our beck and call. All are utilized in the treatment of diseases. Sane men will not follow a charlatan. But if any trustworthy guide, be he physician or layman, proves that a given remedy is of value in the treatment of diseases, we will utilize it and will honor him. We should not be compelled, however, as Zinsser remarks, to eat an entire artichoke in order to get a tiny bit of really edible substance. There are, regarding healing, many decidedly fractional truths. As to some of them, the term "half truth" is an unwarranted exaggeration. "Nay," said Lord Bacon, "we see the weakness and fragility of men in sickness, as they will often prefer a mountebank or witch before the learned physician, and therefore the poets were clear sighted in discerning this folly when they made Aesculapius and Circe brother and sister, both children of the Sun."

All nonmedical agencies are enthusiastic endorsers of health examinations. Life insurance companies quickly saw a great saving in the postponement of the termination of premium periods by early detection and correction in their beginnings of chronic and fatal maladies. And the persons insured also gain, for they have their lives conserved and their longevity prolonged. Social health agencies promptly recognize a probable reduction in the cost to the public of care of the indigent sick, a wonderful increase in well-being and freedom from painful and distressing illness, and a consequent great contribution to human happiness. Yet periodic health examinations are primarily a practicing physician's direct obligation. Nothing is better calculated than they to bring about the continuity of the long-established and mutually confidential relation of the medical profession with the community it serves. To be successful, however, the idea of health examinations would require a real campaign, with the laity cooperating.

Let us have a drive for the prevention of illness by making a survey of the apparently well and devising an inventory for right living and for properly planned hygiene for the needs of each individual case among our apparently robust patients—a drive to treat the incipiently sick while they can be cured.

We will treat the mind as well as the body. It will give the opportunity to ask that most important of all questions in the investigation of the chronic case; viz., "Are you happy? If not, why not?" Can any one give more sympathetic and sane advice about the abstruse mental and emotional problems of life than the resourceful, experienced, tactful physician? Is his not the buoyant, commanding personality by virtue of the peculiar oracle-like relation which he sustains to his patient to be the scientific and sympathetic Samaritan?

> Canst thou not minister to a mind diseased,
> Pluck from the memory a rooted sorrow,
> Raze out the hidden troubles of the brain,
> And with some sweet oblivious antidote
> Cleanse the stuff'd bosom of that perilous stuff
> Which weighs upon the heart?

A health week should be established nationally by all the health agencies of this country, with the cooperation of every one of the 90,000 members of the American Medical Association. The press can be counted on to do its part, which is as essential as it is unfalteringly interested and helpful in all health movements. A manual for the examination is being prepared by the American Medical Association. Examination blanks can be obtained from the headquarters, making for completeness and uniformity. A copy of the examination might properly be given the patients for their information, and one kept by the physician as a permanent record. Last, but not least, is a well considered interpretation of the patient's needs, physical, occupational and mental; and comprehending advice may finally be given to meet his peculiar needs. While it is primarily a technically complete head to toe physical examination, it is more a stock-taking of the patient's physical condition and an annual audit for health guidance.

Kipling tells of a legend in which the gods stole the godhead from man, who was at that time a sort of deity. They agreed to hide it. The wisest of the gods, Brahm, hid this tiny, unstable light of the stolen godhead where man would never dream of looking for it —inside man himself. That has ever since been Brahm's secret and will always be until man himself discovers it. Can the physician not help him to find his lost godhead?

MEDICAL EDUCATION

The stupendous advance in medical education in the last fifteen years reads like a romance. The United States contained 160 good and bad medical colleges, more than twice as many as the rest of the world. These schools have been reduced to eighty strong schools. The course has been doubled in the last three decades. More than one fourth of these schools are departments of state universities. Enormous endowments have made medical education the pampered favorite of private munificence. The medical schools of America can proudly take their place in the sun.

The supply of an adequate number of sane, resourceful, dependable physicians should have the solicitude of the profession as a whole, as well as of the medical educators. The fear has been expressed that we are overtraining our students, that the specialties are so fascinating and their teachers are so enthusiastic that too much time is devoted to them in the undergraduate years. These years should, in truth, be given to basic preparation. The student must in the four years in the medical school encompass all the broad, fundamental principles of medicine. The man who is going to become a specialist should wait until after his hospital internship and preferably some years in general practice before he takes up specialization. A specialty should be a postgraduate study, not a part of a student's first preparation.

The laboratory side also should not be overcultivated. Fundamentals should be stressed, but recondite experimental work omitted in the undergraduate course. Relatively few students are going to be purely research men, and comparatively few are temperamentally fitted for that service. It is impossible really to make of an undergraduate an expert in any of the laboratory sciences. An excess of laboratory instruction, to the deprivation of needed bedside work, will not best prepare the student for the treatment of the sick.

In this desirable correlation between the pure sciences and the clinical subjects, the student of anatomy and pathology should be brought in his first two years into contact with the patient, so that he will appreciate the relationship of his studies to the problems of disease. Much more interest would be evinced in chemistry and bacteriology if every student were early to be given a glimpse of his wonderful relation to the patient. Then later, when the purely clinical work is taken up, it is not wise to abandon the study of biochemistry and physiology. Regarding clinical work in England, the Council on Medical Curriculum has advocated the continuation in the clinic itself of anatomy, physiology, pathology and chemistry, as these apply to the problems of medicine and surgery there presented. In this country our clinical and pathologic conferences have the source of the greatest inspiration.

The new medical school of Vanderbilt University is entirely housed in the hospital, thus linking up the wards with the laboratories in an integral and intimate way. We feel that it will be a distinct gain. It will afford an unparalleled opportunity for the simultaneous study of the medical sciences and the patient. The pathologic department will be a guiding center. Fresh tissue and not merely postmortem of terminal processes will be studied It will concentrate on the causes as well as the development of disease. With the close relation of the dispensary and the hospital, the pathologic department, where all the problems of the patient can be brought and where all the men can work as undergraduates, as interns, as residents and as members of the staff, it ought to foster a spirit of investigative interest in the patient that will be stimulating to the completest possible training.

Our British cousins speak of the American methods as encyclopedic theory, and say that our effort in diagnosis is to make such a thorough study of the patient's state that no cell remains unturned. The student must be taught, as urged by President Hadley, to distinguish between the possession of information and the power or habit of thought. There is no substitute for thinking. Knowledge is proud that he has learned so much; Wisdom is humble that he knows no more.

A physician who gets a good start on a limited original training may go further than his more erudite brother, but he will always be happier and more efficient if he is interested in the humanities. The student must not be allowed to get so interested in the disease that he forgets the patient.

The question of entering the student into practice at an earlier age is important. It is impossible to devote to preliminary preparation less than two years of college work in biology, physics and chemistry, and it is impossible to eliminate anything from the four year medical course. The hospital year is essential. The only chance to curtail the length of time would be by saving one or two years in the high school. This can be done by the four quarter school year and no compulsory vacation at an unchangeable time, thus saving one or two years for the student with medicine as his goal.

SPECIALISM

One of the greatest romances in the art of medicine has been the amazing growth and perfection of the specialties. A man with an adequate training and a wide knowledge of disease, who devotes his entire time and thought to the problems of one department of medicine or one group of organs, can arrive at a surpassing degree of excellence. Some of the most intricate processes of relief for disease and injury are practiced by the specialists with an almost uncanny degree of dexterity. The removal of foreign bodies from the lungs by the bronchoscopic method amounts to legerdemain. The skill that is amassed by employing methods of precision over and over again becomes truly miraculous. The accumulative experience begets wisdom and judgment and a choice of the methods that are the most effectual. The development of the specialties has been possible by the focusing of original and brilliant minds on problems that are beckoning for solution. Specialism is so alluring that it is impoverishing the personnel available for the laboratories and decimating the ranks of the general practitioner. It is astounding what the country doctor, unaided by the panoply of present-day instruments of precision, accomplished by the use of his five senses and that other very essential sense—common sense. "All but eternal doom was conquered by their art."

One of the drawbacks of specialization is that it loses for the physician the personal touch and close contact with the family and with the acutely ill. The family physician has with the family during illness a personal, intimate, sacred relation which the specialist can never enjoy. The general practitioner must retake his former position of importance. The grander domain of internal medicine must remain steadfastly the soul of medicine, the center of the color standard.

THE FAMILY PHYSICIAN

The family physician has ever been the bulwark of medicine. "He shall heal the nations and defraud the tomb." His has been the labor of love as well as a superb endeavor to combat disease and rout it from its citadel. He is confronted with the most desperate conditions and has with rare resourcefulness risen to his responsibilities. The intrepidity of the country doctor in the management of the emergencies of accident and disease, the perils of childbirth, and the mastery of conditions under the most adverse circumstances is unparalleled. His calling exacts, as Kipling said, the utmost that man can give—full knowledge, a steadfast hand, exquisite judgment and skill of the highest, to be put forth not at any self-chosen moment but daily at the need of others. He knows how to gild the gloom of affliction's couch with the silver lining of Hope.

The pagans believed that the physician came from the god of music, since it was his province to keep in tune the harp of a thousand strings. The physician has been eyes to the blind, feet to the maimed, deliverer of the poor; he has caused the widow's heart to sing for joy, and has gained the blessings of him that was ready to perish. He has been the Good Samaritan, and has imitated the benevolent miracles of the Great Physician.

Who will write the epic of the family doctor? Would that a Shakespeare could weave his deeds of bravery, his tender sympathy, his discretion and tact, his cheerfulness and courage, his devotion and fortitude, into an immortal sonnet.

Oliver Wendell Holmes apostrophized the spirit of service:

> Charity is the eminent virtue of the medical profession Show me the garret or the cellar which its messengers do not penetrate; tell me of the pestilence which its heroes have not braved in their errands of mercy; name to me the . . . practitioner who is not ready to be the servant of servants in the cause of humanity, . . . and whose footprints you will find in the path to every haunt of stricken humanity.

Yours is a glorious privilege of "inscribing your memories not on perishable marble but in the living affections of your fellow men." The war trump, the muffled drum, the measured tread of armed men, and the musket shot pealing over the grave honor the death of the soldier, but the physician who meets his death battling for Truth in the great arena of Science passes often to an inconspicuous grave, mourned only by the few who knew his worth.

At the southern entrance of St. Paul's Cathedral stands a statue of Sir Astley Cooper, by Bailey, a beautiful commemoration of the unrivaled surgical reputation of this great surgeon and of his fame as a teacher. Who will erect a monument in bronze or stone to the family physician? Would it not be fitting to perpetuate symbolically the vision of his service and the splendid part that he has played in the pioneer civilization of this country? We have commemorated our statesmen, scholars and warriors. What of the man whose life is spent in the interest of humanity, for preserving their lives instead of the ruthless destruction of their bodies? An unknown British warrior lies in the crypt of Westminster Abbey to commemorate the spirit, the bravery and the sacrifice of his fellows. Above him is inscribed:

> They buried him among the Kings because he had done good toward God and toward His house.

The French have immortalized their unknown soldier under the Arc de triomphe, typifying the unparalleled fervor, fearlessness and patriotism of the poilu; and we in America have enshrined our unknown soldier at Arlington. It is time that a monument be erected to the unknown family physicians—generations of them—in grateful acclaim of their unfaltering love of duty and ineffable devotion to suffering humanity.

THE DERMATOLOGIST-SYPHILOLOGIST IN THE UNITED STATES *

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The question, "Why should the dermatologist be supposed to have special qualifications as a syphilologist?" appears to be the approved form for the expression of the opinion that, in the enthusiasm for reorganizations and new starts which possesses a part of the medical world, the specialties of dermatology and syphilology, formerly supposed to be "indissolubly bound together . . . in a union profitable to the progress of science," should be divorced, and a new type of syphilologist created.

Is the proposed change needful or likely to be advantageous to the future welfare of medicine?

In this country, as in continental Europe, the dermatologist has been a syphilologist since these branches of medicine developed into specialties. This is not for the reason, which some pretend to believe, that the dermatologist considers syphilis to be chiefly a disease of the skin; for he has always held, with Auspitz, that the skin is a "Janus with two faces, one of which receives the impressions from the exterior, while the other is turned toward the internal laboratories of the body." In the field of syphilis, at least, he has not neglected to search for disturbances in the "internal laboratories"; and though he has abandoned the internal treatment of scabies, and treats most skin diseases externally, yet, with Brocq, he sees more and more the necessity for the "general treatment of patients afflicted with dermatoses."

DEVELOPMENT IN THE UNITED STATES

When, half a century ago, dermatology began to develop in this country, syphilology occupied a prominent place at its side. Our first journal was entitled the *American Journal of Syphilography and Dermatology*, and complaint was heard that it devoted too much attention to syphilis at the expense of dermatology. When the New York Dermatological Society, the oldest dermatologic society in existence, was founded, Dr. Weisse, probably as a protest against neglecting dermatology for syphilis, urged that the society devote itself to dermatology alone. His views were not long heeded, and the members of this society, as well as those of all other dermatologic societies since founded in this country, have been equally diligent in the two fields of medicine. It is true that our societies have for the most part been called "dermatological societies," and the numerous changes of name of our journal, and of this section, show the difficulties in choosing a properly descriptive and euphonious name for the com-

* Chairman's address, read before the Section on Dermatology and Syphilology at the Seventy-Sixth Annual Session of the American Medical Association, Atlantic City, May, 1925.

bined specialties. The dermatologist-syphilologist is invariably called a dermatologist. The awkwardness of the attempted combined appellations is enough to discourage their use, but the chief reason for their almost total disuse seems to be the fact that, outside of medical circles, the word syphilis was ostracized, because the public considered the disease "a punishment inflicted by God upon the Knight of Venus," or, as Cotton Mather expressed it, "that filthy disease which the just Judgment of God had reserved for our later Ages; wherein so many Fools abandon themselves to the destructive Debaucheries of Unchastity." The public even now is none too willing to entertain Fournier's tolerant view that "specific treatment is a sort of baptism which cleanses them of the original sin."

The omission of the word syphilis in connection with dermatology has no doubt been partly responsible for the present tendency to look on the dermatologist-syphilologist as purely a dermatologist. Perhaps the readjustment of allied specialties has also been partly responsible for this tendency. Twenty-five years ago, syphilis and venereal or genito-urinary diseases were frequently grouped together and treated by the same specialist. With the recent rapid and brilliant development of urology and genito-urinary surgery, the dermatologist immediately and properly abandoned that field, which requires so different a technical training as completely to separate it from dermatology-syphilology. Today no dermatologist-syphilologist makes any pretense of being a urologist or genito-urinary surgeon. On the other hand, some of the older genito-urinary surgeons were and still are known as syphilologists, and a considerable number of the younger urologists include syphilis in their practice, though in the larger cities most of the latter look on it as a side-line, to be abandoned when strictly urologic practice becomes sufficient to warrant that course.

Furthermore, many venereal disease clinics have been established to meet the demand for the care of the patients with these diseases, who were induced to seek earlier and better treatment by the antivenereal propaganda of the war and postwar periods. There were not enough urologists and dermatosyphilologists to man these clinics, and physicians were rapidly trained in the technic of the treatment of venereal diseases to supply the demand. Many of these physicians have so educated themselves that they are competent to handle the diseases, including syphilis, that are found in these clinics. There is no question of the usefulness of this class of physicians. In private practice and in venereal clinics in smaller cities, unable to support the separate specialties of urology and dermatosyphilology, they are well nigh indispensable.

DERMATOLOGY AND SYPHILOLOGY IN THE MEDICAL SCHOOLS

In order to get an idea of the view taken by medical educators as to what position dermatology and syphilology should occupy in the medical schools, catalogues were requested from all the Class A schools in the United States, with the exception of those schools which give only the first two years of the medical course. Fifty were received. In nineteen of these schools there is a professor of dermatology and syphilology. In thirteen there is a professor of dermatology, but, as the instruction in both dermatology and syphilology is in this department, dermatology includes syphilology. In one school, there is a professor of dermatology and a clinical professor of syphilology. Thus thirty-three of the fifty schools associate dermatology and syphilology, either in a department of that name or in a department of dermatology.

In the remaining seventeen schools, syphilis occupies positions not readily classifiable. In eight schools, it is in the department of surgery or of genito-urinary surgery. The catalogues of four schools make no mention of syphilis. In one school, an associate professor of clinical medicine has charge of syphilis. In one, syphilis is in charge of an assistant in medicine. In one school there is a clinical professor of dermatology and contagious diseases. In one there is a professor of dermatology and urology, at the head of a department of dermatology and urology, giving a course in dermatology and syphilis. In one school there is a clinical professor of surgery and dermatology, with a subdepartment of dermatology in the department of surgery. In one school there is a professor of dermatology, who is also lecturer in another department on the principles of homeopathy and the organon. In the same school, there is an associate professor of genito-urinary diseases in whose department there is a course on venereal diseases and hernia.

While it is regrettable that the attempt to obtain information from all the Class A medical schools was unsuccessful, the inference from the data obtained is that two thirds of the schools agree that dermatology and syphilology should be united. The incongruous and varied positions taken by the other schools indicate confusion of views, or else the view that syphilis is of no importance in a medical curriculum.

These figures show how syphilis and dermatology are grouped in medical schools, but they show little or nothing of the estimate of the value of the dermatologist or syphilologist. Occasionally there is some intimation of it in the catalogue. The position of the professor varies greatly. Sometimes he is really a professor, with a voice in the affairs of the school. Frequently he has that title, or the title of clinical professor, but in reality occupies an insignificant position. It is not easy to get specific information on this point or on the amount of equipment furnished the dermatologist-syphilologist in the dispensary and hospital, whether attached or unattached to a medical school. Such information must be obtained by personal observation or inquiry, A detailed study of this subject would be instructive.

A conservative statement is that there is the greatest variation in the estimate of the value of the services of the dermatologist-syphilologist and the greatest variation in the support given him in school, hospital and dispensary. There are very few places where there is equipment for any sort of investigative work. There are few hospitals, even in the larger cities, in which there are special wards for diseases of the skin, for syphilis, or for diseases of the skin and syphilis. There is a larger number in which there is a service in charge of a dermatologist-syphilologist, with patients scattered through the different wards. There are more in which the dermatologist or syphilologist is only a consultant, and there are still many hospitals to which patients with severe diseases of the skin and with open syphilis are admitted with reluctance, and with these, if there is a dermatologist or syphilologist on the staff, the hospital connection is nominal.

The situation in the dispensaries is similar. There are a few in which adequate support is given the dermatologic service both in personnel and in equipment; but in a very large number the support is small and the equipment inadequate, and in some there is nothing that can be described as support or equipment. Some of the well equipped dispensaries connected with strong institutions have been financed by the clinical staff itself.

The worth of the work of the dermatologist-syphilologist to his colleagues may be roughly estimated by the support and equipment given his clinic. In several places where good equipment has been furnished and where cooperation has been cordial, satisfaction, joined with mild astonishment, has been expressed at the demonstration the dermatologist-syphilologist has given of his usefulness to other departments. On the other hand, where dermatology-syphilology is not permitted to develop, dermatology is regarded more or less as an idle amusement, and syphilis as a disease that may be well enough cared for in any department that stumbles on it.

The view of the position that dermatology and syphilology should occupy, entertained by one of the schools committed to the policy of full-time medicine, is of interest. A recent official announcement states that "dermatology and syphilis . . . will for the present remain subsidiary to clinical medicine and will develop either through the interest and ability of clinical instructors, assisted by the section on medicine, or by junior members of the full-time staff of the section on medicine, who may be imported on account of their interest in one of these specialties after a thorough grounding in internal medicine, or who may be given the opportunity to specialize in one of these fields." And on the other hand, as the reward of their interest and ability, the part-time clinical workers in dermatology and syphilis are to be granted "in return, the advantages of the clinics and its laboratories *at the discretion of the professor of medicine*" (italics mine—J. E. L.).

It is perhaps only fair to state that this school attempts to have as much as possible of the teaching, and of the clinical and "research" work done by full-time physicians, and discourages its intramural disciples from extramural contact with practitioners of medicine. Such of these as are connected with the school, under whatever title, occupy subordinate positions, on one year appointments, with no voice in the direction of affairs.[1]

THE SITUATION IN GERMANY

It is rather disheartening to do so, yet it may not be out of place to compare our situation with that of our colleagues in Germany, where the experiences of the war demonstrated the great value of dermatology-syphilology and stimulated its development. Veiel, in his opening address at the Congress of the German Dermatologic Society in May, 1923, said:

> The importance of our specialty is becoming more and more recognized by the state and by the universities. In almost every university there are now full professors of dermatology and syphilology, for the most part with new clinics. Our specialty has been the object of investigation, and as a result a better education of physicians in the specialty is assured. Yet we must not on this account relax our efforts, but must continue to strive that not only in the universities but also in the hospitals of the larger cities there shall be established special departments for dermatology and syphilology under the direction of colleagues of our specialty.

NEEDLESSNESS OF SEPARATING DERMATOLOGY AND SYPHILOLOGY

From the preceding remarks it may be inferred that the creation of the neosyphilologist does not seem to be a necessity, and that there are good reasons for continuing the established custom of combining dermatologist and syphilologist, and for supplying facilities for improving his work.

In the first place, the dermatologist is of necessity to some extent a syphilologist. In the days when syphilis was chiefly known by its skin manifestations, the necessity was perhaps more apparent than now, when skin manifestations are diminishing with earlier and more efficient treatment. The converse is also true that formerly the syphilologist was of necessity a dermatologist. And it is true today that, in spite of the various tests, each of which is of assistance but all of which combined do not tell all the tale, the syphilologist who is not a clinical dermatologist labors under a great handicap. Incidentally, the syphilologist, who is a syphilologist only, should he announce himself as such, could hardly exist by the practice of his specialty, for the intelligent syphilitic patient is not yet willing to disclose the nature of his disease by frequenting the office of a physician treating syphilis only. Even in the dispensaries where there are separate clinics for syphilis it has been camouflaged under "Special Medicine," "Department L," or some other emasculated name.

In the second place, the fact is that at present the leading clinical syphilologists of this country are dermatologists. The exceptions are so few that they are notorious. This fact, in connection with the fact that the dermatologist-syphilologist has been able to maintain this position in spite of inadequate support, is corroborative evidence of his industry and ability in both fields.

Thirdly, the best training places for the syphilologist are the dermatologic clinics, which have grown up where the dermatologist-syphilologist has been allowed to develop his clinic. The number of such clinics has been gradually increasing.

These and similar facts are recognized by many as sufficient reason for continuing the union between dermatology and syphilology. The New York Academy of Medicine some years ago created a section of dermatology and syphilis, and it is gratifying that within a few years the American Medical Association has given its official approval to the union, by renaming this section the Section on Dermatology and Syphilology, and by naming its journal the *Archives of Dermatology and Syphilology*.

NEED FOR INCREASED FACILITIES

While conditions under which the dermatologist-syphilologist works have improved in some places in recent years, they are still so far from satisfactory, in most medical schools and hospitals, that it is not an exaggeration to say that his work has been remarkably good in the light of the generally meager facilities. That we have accomplished as much as we have is undoubtedly largely due to our spirit of cooperation. To quote Pusey, changing the tenses, "If there has been any rivalry between us, it has been the sort of friendly rivalry which exists between brothers, each of

1. It is somewhat aside the point, but it is interesting that this same official announcement, as an argument for full-time medicine, states that "it seems fair to assume that . . . the clinical sections of the leading schools of the country would have adopted a university basis [i. e., full time—J. E. L.] as medicine became more and more a science and less and less an art." Even if this is true, is it not unfortunate and unnecessary that the art of medicine should decline with the advance of the science of medicine? It is conceivable that it may be a necessary and unfortunate result of the policy of full-time medicine carried to the extreme of monastic seclusion from the practitioners of medicine.

whom is as proud of the other's accomplishments as of his own."

The dermatologist-syphilologist cannot develop as he should, he cannot fulfil the function he should in the medical school and in the hospital, he cannot give his colleagues the assistance he should give them, he cannot receive from his colleagues the assistance he should receive from them, nor can he do the investigative work he should do in diseases of the skin and in syphilitic diseases, without an intimate contact with associates and patients, which can be obtained only when he has at his disposal hospital patients and hospital and laboratory facilities.

Fifteen years ago, Wende, in his address as chairman of this section, said: "We as dermatologists should make some effort to bridge over the ever widening separation between our specialty and the field of internal medicine." Two years ago, Haase expressed the opinion that we were farther apart than before. If this is so, it is not entirely the fault of the dermatologist-syphilologist,[2] and if the problem is to be satisfactorily solved it would seem that it will be solved by giving the dermatologist-syphilologist the opportunity to develop. How can he be of full value under any other conditions?

It may be objected that the dermatologist is not always a syphilologist. It is true that some dermatologists have neglected syphilis and confined themselves chiefly to dermatology. In some instances this may have been due to personal preference, but in most cases it has undoubtedly been due to the fact that they have not had access to the necessary facilities, and that the difficulties seemed insuperable without these facilities. But if one is to be a syphilologist, one must have adequate knowledge of all of the disease. This is true in spite of the fact that some of the manifestations of syphilis also logically fall into other specialties. For example, the neurologist is expert in syphilis of the nervous system, which frequently does not reach him until clinical signs of the disease have developed; but the syphilologist who neglects this field fails to fulfil one of his most important functions, which is to discover and treat involvement of the nervous system before, as well as after, clinical signs manifest themselves. If we are to hold the position we have gained as dermatologists and as syphilologists, and to advance it, we must strive to obtain more facilities for the study of diseases of the skin and of syphilis in all their phases.

HIGH STANDARDS

The standards of the dermatologist-syphilologist have in the past been kept rather high. Dermatologists were few, and most of them had excellent training for which, until not so long ago, they were compelled to go to Europe. As our cities grow larger there is an increasing field for the dermatologist-syphilologist, and several of our clinics have developed excellent opportunities for training in our specialties. With a larger field and accessible clinics, there are already signs that we may be confronted with the problem of inadequately trained, incompetent persons setting themselves up as dermatologists, as has been the case in other specialties. This problem has been foreseen, and three years ago a committee of the American Medical Association reported on it. This report covered chiefly the educational requirements deemed necessary for training the dermatologist-syphilologist and insisted on the necessity of adequate preliminary training in internal medicine. It is probable that it will be long before legislatures even consider the question of requiring examinations for specialties, and such procedure is the only one that will have wide effect in protecting the entrance into specialties. On the other hand, in order to keep up our own standards, it would perhaps be wise to consider limiting the membership of dermatologic societies to qualified dermatologists-syphilologists. Many new local societies are being formed, and, as such societies are one of the best means of education, it is not wise to make the requirements for admission too severe; but they should not be so low as to give to an incompetent a local professional standing he does not deserve.[3]

The future of dermatology-syphilology in this country should be better than its past. With enlarged possibilities for work, there should be better work. Ours is not a narrow specialty, and with increasing knowledge of internal medicine, it is of necessity becoming broader and broader. Let it not become shallow as it becomes broader. As Paget said: "The fault of specialism is not in narrowness, but in the shallowness and the belief in self-sufficiency with which it is apt to be associated."

As we remind others of Osler's "Know syphilis in all its manifestations and relations, and all other things clinical will be added unto you," let us not forget to remind ourselves of Ricord's "I may fearlessly assert that a thorough knowledge of all other diseases is eminently necessary in order to study syphilis effectually." If we remember this we shall not fall into the "belief in self-sufficiency."

All branches of medicine, and none more than ours, need cooperation with the other branches. With all the modern methods of precision, with all the advances in the science of medicine, the cultivation of the art of medicine is still essential, and for many years to come we shall have to say, with Hippocrates, "It is a task to acquire sufficient accuracy to make only occasional mistakes, and I am full of admiration for the physician whose mistakes are small, for perfect accuracy is seldom seen."

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2. Our program this year contains a paper on a dermatologic subject by an internist, evidence of our desire to cooperate with and receive information from others.

3. Perhaps it will not be out of place to suggest that when new societies are formed the name Society of Dermatology and Syphilology be adopted instead of Dermatological Society. This might be an advantageous change to make in the names of older societies, except for the fact that an ancient society dislikes to modify an honorable name.

Dick Test Before and After Immunization.—In the latter part of November, 1924, scarlet fever appeared among the 328 inmates of a boy's school located in the District of Columbia. The Dick test was made on each of the boys, and those showing positive reactions were given injections of the scarlet fever streptococcus toxin for purposes of immunization against scarlet fever. Three weeks after the last immunizing dose of toxin, a retest was made to determine the degree of immunity produced against the toxin. Of the total number tested, 17.1 per cent. gave a positive reaction. The boys showing positive reactions were divided into two groups. One group was immunized with toxin to which no preservative had been added, while the second group was immunized with the same toxin containing 0.5 per cent. phenol (carbolic acid). Three weeks from the date of the final immunizing dose, each immunized boy was retested with a test toxin to which no preservative had been added and with the same toxin containing 0.5 per cent. phenol. The preserved toxin used in immunization seems to have given better results than the toxin that contained no preservative. There was no indication that the addition of the 0.5 per cent. phenol to the toxin in any way vitiated its immunizing potency. It is not thought that the data presented can be interpreted in favor either of a medium control alone or of a heated control.

THE TREATMENT OF DIABETES MELLITUS IN CHILDREN *

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The subject matter in this paper was originally prepared as a guide for the teaching of medical students. The lack of publications dealing especially with the treatment of diabetes mellitus in children has led to the presentation of the material in the hope that it may prove of service to those whose experience with the disease has not been extensive. The physician who has evolved his own system of treatment will find it elementary and unnecessary.

INSULIN

In the modern treatment of diabetes, both dietary regulation and insulin administration are employed; and there is sufficient knowledge about both of these measures to permit, within certain limitations, almost mathematical precision in the use of them. In an individual case the carbohydrate tolerance can be ascertained, and the assistance required of insulin can be calculated in terms of units of this substance. Before discussing the details of treatment, a brief consideration of insulin is necessary. This substance is an aqueous solution of the active principle or hormone of the islands of Langerhans of the pancreas. As prepared for use, the glucose equivalent of 1 unit of insulin is about 2; i. e., it is standardized so that 1 unit will enable a diabetic patient to metabolize about 2 gm. of glucose-forming food. It should be remembered that there is an individual variation in this respect and also that with each added unit given, less and less glucose per unit is burned up.

Insulin should be given subcutaneously, care being taken that it is not injected too near the skin or intramuscularly. In coma it may be administered intravenously. When ingested, it becomes inert; by inunction and when dissolved on the tongue, it is absorbed slightly but in ineffectual amounts. It is best injected from fifteen to thirty minutes before meals, in severe cases in which there is diacetic acid in the urine before each meal, but in milder types twice or perhaps only once a day. After injection of insulin, the blood sugar begins to fall and the effect lasts from six to twelve hours. Insulin by no means replaces dietary measures but simply assists them by supplying the deficient pancreatic hormone. In order, then, to regulate the amount of insulin to be given, it is necessary to know how much glucose is ingested and how much the patient can metabolize. It need not be administered at all if a diet can be found which will keep the patient's urine sugar free, and which is so balanced that the fatty acids will be metabolized further than the ketone stage while at the same time the patient is maintained in a normal nutritional state with allowance for necessary activity. Many adult diabetic patients can get along without insulin, but practically all diabetic children will be benefited by its use, the severity and progressive character of the disease in them making it difficult to give a diet that will keep them sugar and ketone free while supplying enough food for growth and development. It is also to be hoped that in some instances the administration of insulin may give sufficient rest to the pancreas to enable regeneration of the tissue in the islands of Langerhans to take place and the course of the disease to be arrested.

DIET

The diabetic diet should be planned with three definite factors in mind: (*a*) the protein content; (*b*) the relation between ketogenic and antiketogenic substances, and (*c*) the glucose tolerance of the patient. It may be assumed that a child will require at least 1 gm. of protein for each pound of body weight. Protein-containing foodstuffs are selected that will furnish this amount. It has been shown by Shaffer and independently by Woodyatt that there is a rather definite quantitative relationship between the amount of glucose and the amount of fatty acid that can be metabolized without ketone bodies remaining and the consequent danger of acidosis. That is to say, ketogenic food substances must be balanced against antiketogenic food substances. Without entering into a theoretical discussion of the subject, it may be said that, from a practical standpoint, if the diet contains not more than 2.5 gm. of fat for each gram of carbohydrate plus each gram of protein, ketosis will not occur. This proportion is based on the fact that the total fatty acid in the diet should not be more than one and one-half times the total available glucose. The fatty acid (ketogenic) fraction is formed by 90 per cent. of the fat and 46 per cent. of the protein, and the glucose (antiketogenic) fraction by 10 per cent. of the fat, 58 per cent. of the protein and 100 per cent. of the carbohydrate. This may be expressed by the formula $\frac{K}{A} = \frac{0.46\,P + 0.9\,F}{0.58\,P + 0.1\,F + C} \cdot \frac{K}{A}$ should not be more than 1.5. To put this in a more convenient form: Fat (gm.) = 2 Carbohydrate (gm.) + 0.5 Protein (gm.).

This means, then, that in continuing the planning of the diet in which protein has already been supplied in the proportion of 1 gm. per pound of body weight, the remainder of the food must be added so that there is 1 gm. of carbohydrate and not more than 2.5 gm. of fat for each pound of body weight. Children are especially prone to the development of acidosis, and it is well to keep the fat lower than would be permissible in adults, not much more than 2 gm. of fat being allowed per pound of body weight. This is particularly important in initial diets until the glucose burning power of the body is known. The high fat diets advised by Newburgh and Marsh should be used cautiously in childhood.

Before one proceeds with treatment and prescribes the diet, the cases must be divided into three groups: (1) those uncomplicated cases in which diacetic acid is absent from the urine; (2) those in which diacetic acid is found in the urine, and (3) those in which symptoms of acidosis and coma are present. Diacetic acid rather than acetone should be the criterion, because the latter is too delicate a test. The presence of diacetic acid in the urine indicates a real danger, as it shows a considerable disturbance of fat metabolism.

TREATMENT OF UNCOMPLICATED CASES

In the treatment of uncomplicated cases (in which there is no diacetic acid), the details may best be illustrated by giving the procedure in the following hypothetic case: Suppose that a diet is to be prescribed for a diabetic child whose weight is 50 pounds. Table 1

* From the B. K. Rachford Department of Pediatrics, University of Cincinnati College of Medicine.
* A fuller discussion of the subject of diabetes in children will be found in the forthcoming edition of Griffith's Diseases of Infants and Children.

TABLE 1.—*Values of Foods as Prepared for Use, Without Addition of Butter, Lard, Oil or Sugar*

	Household Measures			100 Gm. Portions		
	P (Gm.)	F (Gm.)	C (Gm.)	P (Gm.)	F (Gm.)	C (Gm.)
Foods Highest in Protein:						
Dried beef (30 gm. or 1 oz.)	12	2	0	40	6	0
Lean meat (100 gm. or size 1 chop)	25	12	0	25	12	0
Chicken, stewed (100 gm. or 1 slice size 1 chop)	22	5	0	22	5	0
Chicken, roasted (100 gm. or 1 slice size 1 chop)	20	16	0	20	9	0
Sweetbread (100 gm. or 4 h. tbs.*)	20	9	0	20	9	0
Cottage cheese (30 gm. or 2 h. tbs.)	6	0.5	1	20	1.5	3
Fish, boiled (100 gm. or 4 h. tbs.). Cod, flounder, whitefish, shad, trout, salmon, haddock	18	5	0	18	5	0
Egg (50 gm. or 1 av. size).	6.5	6	0	13	12	0
Egg white (33 gm. or 1 av. size)	4	0	0	12	0	0
Milk, whole (30 c.c. or 1 oz.) sweet or lactic acid.	1.2	1.2	1.2	4	4	4
Skimmed milk (30 c.c. or 1 oz.) sweet or lactic acid.	1.2	0	1.2	4	0	4
Gelatin (30 gm. or 1 h. tbs.)	1	0	0	3	0	0
Broth (30 c.c. or 1 oz.)	0.75	0	0	2.5	0	0
Foods Highest in Fats:						
Olive or salad oil or lard (13 gm. or 1 tbs.)	0	13	0	0	100	0
Butter (15 gm. or 1 ball or 1 r. teaspoonful)	0	12	0	0	85	0
Bacon (30 gm. or 1 large slice)	3	20	0	10	72	0
Egg yolk (18 gm. or 1 av. size)	2.5	6	0	13	33	0
Cream, 20% (30 c.c. or 1 oz.)	1.2	6	1.2	4	20	4
Cream, gravity or 16% (30 c.c. or 1 oz.)	1.2	5	1.2	4	16	4
Baked custard (50 gm. or 1 h. tbs.)	3.5	3.5	1	7	7	2
Foods Highest in Carbohydrate:						
Sugar (10 gm. or 1 h. teaspoonful)	0	0	10	τ	0	100
Cereals and Starches:						
Shredded wheat (30 gm. or 1 biscuit)	3	0	23	10	0	75
Cornflakes (20 gm. or 1 h. tbs.)	1.75	0	15	8.75	0	75
Bread, wheat (30 gm. or 1 small slice, 3", 3½", ½")	3	0	16	10	0	53
Gluten bread (40 gm. or 1 small slice, 3", 3½", ½")	12	0	12	30	0	30
Potato, baked (40 gm. or 1 h. tbs.)	1	0	10	2.5	0	25
Rice (100 gm. or 1 h. tbs.).	3	0	24	3	0	24
Oatmeal, Ralston's, Pettijohn's (50 gm. or 1 tbs.)	2.5	1	10	5	2	20
Potato, boiled (50 gm. or 1 h. tbs.)	1	0	10	2	0	20
Macaroni or hominy, boiled (50 gm. or 1 h. tbs.)	1.5	0.5	8	3	1	16
Cream of wheat (50 gm. or 1 h. tbs.) farina	0.75	0	5.5	1.5	0	11
Saltine cracker	0	0	2	..	..	..
Butter thin	0	0.5	2.75	..	..	..
Soda cracker (3" sq.)	0.5	0.5	4	..	..	..
Graham cracker	0.75	0.75	6	..	..	..
Vegetables:						
Lima beans (49 gm. or 1 h. tbs.)	3	0	12	7.5	0	30
Green peas (30 gm. or 1 h. tbs.)	2	1	4	6.5	3	13
10% vegetables (50 gm. or 1 h. tbs.). String beans, carrots, turnips, beets, squash, onions, pumpkin.	0.5	0	3	1	0	6
5% vegetables (50 gm. or 1 h. tbs.)	0.5	0	1.5	1	0	3
Fruits:						
Apricot, dried (8 gm. or 1 av. size)	0	0	5	3	0.5	62
Prune (10 gm. or 1 small).	0	0	6	1.75	0	60
Plum (35 gm. or 1 av. size)	0	0	7	0	0	20
15% fruits (25 gm. or 1 tbs.). Raspberries, blueberries, cherries, currents	0	0	3.75	0.75	0	15
Banana (195 gm. or 1 av. size)	1.5	0.75	28	0.75	0	14
Pear (150 gm. or 1 av. size)	0.75	0.5	20	0.5	0	13
Pineapple (50 gm. or ½ slice)	0	0	5	0	0	10
Apple (150 gm. or 1 av. size)	0.5	0.5	16	0	0	10
Grapefruit (200 gm. or ½ av. size)	1.5	0.5	20	0.75	0	10
10% fruits (25 gm. or 1 h. tbs.). Blackberries, strawberries, gooseberries	0	0	2.5	2	0	10
Orange (125 gm. or ½ av. size)	0.75	0	10	0.5	0	8
Peach (125 gm. or 1 av. size)	0.5	0	10	0	0	8
Lemon (65 gm. or 1 av. size)	0.5	0	3.5	1	0	6

* 1 h. tbs. = 1 heaping tablespoonful.

is consulted, and the foods selected are ordered either by weight or by household measure as in Table 2. By employing the formula $F = 2C + 0.5\,P$, it is seen that ketogenic-forming substances are distinctly less than the antiketogenic ($84 < 100 + 25.5$. Such a diet may well serve as a basic one for any diabetic child. If the patient's weight is less or more than 50 pounds, the amounts of food can be divided or multiplied by the desired factor. Thus, if a diet is to be ordered for

TABLE 2.—*Foods for a Diabetic Child of Fifty Pounds*

	P (Gm.)	F (Gm.)	C (Gm.)
Egg (100 gm. or 2 av. size)	13	12	0
Lean meat (100 gm. or size 1 chop)	25	12	0
Butter (30 gm. or 2 butter balls)	0	24	0
20% cream (100 c.c. or 3½ oz.)	4	20	4
Olive oil (13 gm. or 1 tbs.)	0	13	0
Orange (60 gm. or ¼ av. size)	0	0	5
Oatmeal (100 gm. or 2 tbs.)	5	2	20
Macaroni (50 gm. or 1 tbs.)	1.5	0.5	8
10% vegetables (100 gm. or 2 tbs.)	1	0	6
5% vegetables (100 gm. or 2 tbs.)	1	0	3
Soda cracker (6 gm. or 1 cracker)	0.5	0.5	4
	51	84	50

a patient of 25 pounds, half the amounts can be prescribed, or if for a patient of 75 pounds one and one-half times the amount of food is allowed. Amounts inconvenient for measurement can be eliminated by change in selection of the foods. The food should be divided into three parts so that approximately one-third of the carbohydrate is given at each meal as, for instance, in Table 3.

TABLE 3.—*Division of Food so that One Third of Carbohydrate is Given at Each Meal*

Breakfast	C (Gm.)	Dinner	C (Gm.)	Supper	C (Gm.)
Orange (¼)	5	Meat (size 1 chop)	0	Oatmeal (1 tbs.)	10
Oatmeal (1 tbs.)	10	Macaroni (1 tbs.)	8	Egg	0
Cream (1 oz.)	1.3	10% veg. (2 tbs.)	6	Cream (2½ oz.)	2.6
Egg	0	5% veg. (2 tbs.)	3	Soda cracker	4
Butter (1 ball)	0	Olive oil (1 tbs.)	0	Butter (1 ball)	0
	16.3		17		16.6

The diet just described has fulfilled certain requirements previously outlined. It has also furnished vitamins and residue. Its digestibility is not as great as that of a nondiabetic diet, because of the high percentage of fat and the overbalance of animal protein. Variety can be obtained by substitution of various vegetables, cereals and fruits; and as increases are made, the selection can be from foods of different character.

TABLE 4.—*Average Caloric Requirements*

Age (Yrs.)	Calories per Pound	Calories per Kilogram
2–4	34	75
4–7	32	70
7–10	27	60
10–14	22	48

There remains to be ascertained whether such a diet is of sufficient caloric value to maintain the child in a good nutritional state and allow for activity and growth. If the number of grams of protein and carbohydrate are each multiplied by 4 (caloric value of 1 gm. of protein or carbohydrate) and the number of grams of fat are multiplied by 9 (caloric value of 1 gm. of fat), the total caloric value of the diet can be obtained. Thus, in the diet planned above, the caloric value is

1,160. If the patient under consideration is 9 years of age, the caloric requirement per pound daily is about 27 (Table 4) and the total calories in the diet should be about 1,350. On the diet planned, therefore, it is unlikely that there will be sufficient food allowance for activity and growth, although there may be enough for maintenance. This becomes more apparent if the normal weight is considered (Table 5). The diabetic patient who has not been under treatment is usually underweight, but has a caloric requirement that should be judged on the basis of normal weight, and the effort

TABLE 5.—*Normal Weight*

Age (Yrs.)	Average Weight Pounds	Average Weight Kilograms
2	29	13
3	34	15.5
4	37	17
5	42	19
6	45	20
7	49	22
8	53	24
9	58	26
10	64	29
11	70	32
12	78	35.5
13	87	40
14	96	43.5

should be to bring the weight gradually up to this standard. Some authorities believe that the nutritional aim should be to maintain the weight at about 10 per cent. below the normal. Care should be taken not to confuse the edema that occurs with undernutrition and the administration of sodium bicarbonate or large amounts of salt in broths and vegetables for actual gain in weight. If the patient becomes sugar free in four or five days and remains so on the diet as planned and diacetic acid is absent from the urine but the caloric intake is too low, the food may be increased every two or three days by adding about 5 gm. of carbohydrate and twice as much fat (10 gm.), the protein remaining about the same. It is not necessary that the carbohydrate and the fat be raised at the same time. In the basic diet it will be noted that the fat is well under the upper limit permitted, and it may be increased before carbohydrate is added, provided it does not supply more than 2.5 gm. per pound and does not overbalance the ketogenic-forming material—the latter consideration being determined by the use of the formula $F = 2C + 0.5\ P$. If glycosuria persists on the initial diet or on the subsequent increases before the caloric intake is sufficient, insulin must be given. It is possible, of course, to diminish the carbohydrate lower than recommended in the initial diet, i. e., below 1 gm. per pound; but a child whose tolerance is less than that amount should be treated with insulin rather than starved.

There are several methods of regulating the dose of insulin, of which the following is satisfactory: The amount of sugar in a twenty-four hour specimen of urine is determined, and as the day's dose one half as many units of insulin are given as there are grams of sugar. If only 5 units is necessary, this dose may be given before the morning meal: up to 30 units may be given equally divided before the morning and evening meal; more than 30 units should be divided into three equal parts and given before each meal. Children are especially liable to develop untoward symptoms as a result of hypoglycemia caused by too much insulin, and if the urine tests indicate that more than 20 units is necessary, it is better to begin with half the indicated dose and gradually increase. When the urine has been found free from sugar for three days, the diet may be increased in the manner previously described. If sugar reappears before a diet of proper caloric value has been reached, the insulin dosage must be increased as indicated by the amount of sugar appearing in the twenty-four hour specimens. If the urine is not examined quantitatively for sugar, insulin should be begun in doses as small as 1 or 2 units three times a day and increased in increments of 1 unit until the qualitative test for urinary sugar is negative. The aim should be to give the smallest dose of insulin necessary. Constant observation of the nutritional state of the patient is necessary, and the urinary sugar should be estimated frequently, so that an increase or decrease in glucose tolerance will be met by a corresponding change in insulin dosage.

TREATMENT OF CASES IN WHICH THERE IS DIACETIC ACID IN THE URINE

The appearance of diacetic acid in the urine indicates faulty metabolism of fat and the danger of acidosis and coma. If only a small amount of diacetic acid is found, the diet should be altered so that the fat is decreased and the carbohydrate increased, the dose of insulin being increased approximately 1 unit for each gram of carbohydrate added. For example, if the patient were on a diet such as that previously described, most of the fat could be removed by eliminating the butter, cream and olive oil, and the oatmeal, macaroni and vegetables increased or other carbohydrate added (Table 6). This diet would furnish only 895 calories, but partial starvation is advisable in the face of a possible acidosis. When diacetic acid has disappeared from the urine, fat and protein are added to the diet in about 5 gm. amounts daily, the carbohydrate and the insulin being diminished until the patient can be treated in the manner outlined for uncomplicated cases.

TABLE 6.—*Diet in Case in Which There Is a Small Amount of Diacetic Acid*

	P (Gm.)	F (Gm.)	C (Gm.)
Egg (100 gm. or 2 av. size)	13	12	0
Lean meat (100 gm. or size 1 chop)	25	12	0
Orange (250 gm. or 1 av. size)	1.5	0	20
Oatmeal (200 gm. or 4 tbs.)	10	4	40
Macaroni (100 gm. or 2 tbs.)	3	1	16
10% vegetables (100 gm. or 2 tbs.)	1	0	6
5% vegetables (100 gm. or 2 tbs.)	1	0	3
Bread (30 gm. or 1 slice)	3	0	16
	57.5	29	101

TREATMENT OF CASES IN WHICH SEVERE ACIDOSIS AND THREATENING COMA ARE PRESENT

With large amounts of diacetic acid in the urine and the onset of such symptoms as restlessness, drowsiness and slight hyperpnea, the patient should be put to bed, external heat applied, an enema given and the stomach lavaged. Fluid is forced and the only food allowed is clear broth, orange juice, oatmeal gruel or 5 per cent. glucose solution. If nausea and vomiting are present, 5 per cent. glucose should be given by rectum. It is very desirable that a blood sugar examination be made and that the carbon dioxid combining power of the blood plasma be determined. Enough glucose should be given to bring about the presence of a small amount of sugar in the urine. The urine should be examined every few hours for sugar and diacetic acid. From 15 to 30 units of insulin should be administered, the amount depending on the urgency of symptoms, the age of the patient, the degree of diacetic acid reaction in

the urine or the results of blood analysis; but in any event each unit of insulin should be buffered by the oral administration of 10 c.c. (⅓ ounce) of orange juice or 1 gm. (1/10 heaping teaspoonful) of glucose or sugar. Subsequent injections of from 10 to 20 units should be given every two to four hours, the amount and frequency being determined by the same considerations as in the case of the original dose. If acidosis has proceeded to the stage of coma, the same plan should be followed but the insulin dosage should be greater (from 30 to 50 units). In advanced cases, insulin and glucose should be given intravenously, a 5 per cent. solution of the latter being injected at the rate of 10 c.c. a minute. If the intravenous route is difficult or impracticable, subcutaneous or intraperitoneal injections may be employed. The amount of glucose used will depend on the symptoms, the age and the weight of the patient and the laboratory examinations, but at least 1 gm. of it must be employed for each unit of insulin. When this would mean that an excessive amount of fluid must be injected intravenously, part of the glucose solution may be given by some other route, or a stronger glucose solution used.

The value of soda in acidosis has been questioned and by some authorities it has been considered harmful. Certainly insulin has rendered it less necessary; but many students of diabetes are not yet ready to discard its use in acidotic states, especially when there is hyperpnea or respiratory distress. In the precomatose stage, a teaspoonful of sodium bicarbonate in 4 or 5 ounces of water may be given every half hour for several doses; if coma is present it may be added in 3 per cent. strength to the glucose solution. An alkaline or neutral reaction of the urine is an indication for the cessation of soda medication. Methyl red, rather than litmus, should be used as an indicator, the red changing to yellow in an alkaline medium.

HYPOGLYCEMIA (HYPERINSULINISM, INSULIN SHOCK)

If an overdose of insulin is given, i. e., more than can be buffered by the available glucose, certain symptoms will arise within from one to five hours. These do not usually occur until the blood sugar is below 0.08 per cent., but they may appear at a level of 0.11 per cent. if a previously high concentration has been too rapidly lowered. Marked shock occurs when the blood sugar reaches 0.04 per cent. Early symptoms of hypoglycemia are sudden hunger, weakness, restlessness and nervousness, pallor or flushing, dilated pupils and increased pulse rate. At this stage the ingestion every ten minutes of such small amounts of carbohydrate as a teaspoonful of corn syrup or sugar, the juice of an orange or a piece of candy will relieve the symptoms. If a large overdose of insulin has been given, there appear the symptoms of sweating, tremor, apprehension, vertigo, diplopia and delirium and, if carbohydrate is not supplied, convulsions, collapse, unconsciousness and death. In advanced states, carbohydrate must be administered by stomach tube; and if improvement is not quickly noted, 20 c.c. of a 50 per cent. solution of glucose should be injected intravenously. If the latter solution is not available, from 10 to 15 minims of a 1:1,000 solution of epinephrin may be injected subcutaneously. Hypoglycemia should be avoided by the careful balancing of glucose intake and insulin injection. When, for any reason, food is not taken or vomiting and diarrhea occur, the insulin should be discontinued.

Infections temporarily and often permanently lower glucose tolerance. During the acute stage of any infection, the food intake should be lowered one half or one third, and after the acute stage the glucose tolerance must again be ascertained before the full diet is resumed.

It is hardly necessary to say that the diabetic patient should be under close observation. If it is possible to do so, a blood sugar analysis should be made every week or two, and the urine must be examined frequently for sugar and diacetic acid. Even children can be instructed to perform the latter tests themselves, and the older ones may also acquire adeptness in calculating diets. Joslin's Manual for Patients is very helpful in this connection. The patient or the patient's attendant should be instructed in the dangers of diabetes and in the mishaps of treatment, and it is well to have these written down so that they may be referred to in an emergency. A list of instructions would include: (1) the early symptoms of acidosis and the measures to be employed in treatment; (2) the early symptoms of hypoglycemia and the measures to be employed in treatment; (3) the indication for the cessation of insulin injections, such as the refusal of food and the presence of vomiting and diarrhea; (4) the danger of infections and the fact that they lower carbohydrate tolerance and consequently require a diminution in food intake. Children must be under close surveillance lest they supplement their restricted carbohydrate allowance in a surreptitious manner.

THE RELATION OF ORTHOPEDICS TO PERSONALITY *

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Personality consists of an individual's collective attributes or qualities. It is the sum total of his traits and, at the same time, the main spring of his being and activities. It comprises his consciousness, his character and his will, and is manifest in his conduct and behavior.

Man's nature has many aspects, and his personality may be considered as the interrelation of certain elements, which are fused into his total being. His anatomy and physiology, his intellectual capacity and his emotional life, help to determine his well being. The inherited potentials of his personality constitute a series of reactive systems which are capable of multiform responses to the stimuli from his environment. His social qualities develop as the result of an interaction of his innate self and the world to which he must adapt himself. A considerable part of his personality is created through living, through reactions to the qualities found in other persons, and through the development of his innate potentials to secure a satisfactory adjustment in life. The capacity for establishing human relationships, and for securing a satisfactory fitness in and through life, is an essential phase of personality growth.

The physical constitution of man is not an isolated phase of his being, but is thoroughly bound up in the totality of his conscious and subconscious life. The physical handicap or deformity is not to be regarded simply as an anatomical deviation, but as an element

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which affects intellectual action, emotional stability and social equilibrium. Whatever hampers the growth of self, and mars or deforms its total development, profoundly influences personality.

EFFECT OF DEFORMITY

During the ages, deformity has had a sinister meaning. The cripple and the monster have been deemed unworthy for society. The ancient Greek condemned to destruction those with bodily defects. Romulus was hailed as a generous law giver when he ordered that all children be allowed to live for at least a period of three years, unless they were lame or monstrous in appearance. Literature abounds in references to those marred in body and similarly warped in soul. Dramatists, poets and historians have dwelt on the frightful personalities accompanying physical deformities. The humpbacked Richard the Third remarks, "I am determined to prove a villain—and hate the idle pleasures of these days." Caliban was "a freckled whelp hag born—not honored with a human shape." There was Thersites, the ugly brawler; Quasimodo, the hunchbacked bell ringer, cruel but devoted; the man who laughed with his slit mouth; the limping Mephistopheles.

Who can tell the effect on William Hohenzollern's personality of his withered arm, or know what relation Byron's club-foot bore to his tumultuous nature and his Don Juan existence? The crippled sport of nature, often outcast of man, could not have had a genial warmth of soul toward a public that ignored him, teased, annoyed and cruelly jested about him. Many possess the opinion voiced by Bacon: "Deformed persons are commonly even with nature for, as nature hath done ill by them, so do they by nature, being for the most part (as the Scripture sayeth) void of natural affection, and so have they their revenge on nature. Certainly there is a consent between the body and the mind, and where nature erreth in the one she ventureth in the other."

ATTITUDE TOWARD THE DEFORMED

But if the cripple was deemed a menace to society, and the deformed were put to death soon after birth, it must be recalled that primitive society entertained opinions and judgments based on economic necessity and religious convictions. The personality of the deformed was, like the deformity, deemed a visitation of a devil and punishment for sin. It is not unnatural, therefore, at a later period, that the sport of the gods should become the sport of men, and play their parts at the courts of kings as entertaining fools and wisdom-yielding jesters. Deprived of normal outlets for activity, the cripple was at the mercy of society and, indeed, found his satisfaction with difficulty, being so dependent on the unfeeling alms-giving of his community. The effect of charity on the recipient cannot always be foretold. The linkage of beggary and crippling was no chance affair. To beg for life was little greater humiliation than to beg for funds. And deformity was often created in children for the purpose of exploiting their services as beggars. It was this phase of purposeful crippling that shocked Vincent de Paul and led him to establish his first institution for the protection of childhood.

Modern civilization has assumed a more liberal attitude toward the handicapped. It is well exemplified in the story of little Eyolf, with the shrunken leg, whose thwarted life was epitomized in the floating crutch—the pale, wan, pathetic child, the only boy who could not swim, and who hopefully aspired to be a soldier. And his father, Allmers, voiced the theory of our day, though he failed in practice, even as we too frequently do today, when he said, "I will try to perfect all the rich possibilities that are dawning in his childish soul. I will foster all the germs of good in his nature—make them blossom and bear fruit. I will do more than that! I will help him to bring his desires into harmony with what lies attainable before him. That is just what at present they are not. All his longings are for things that must forever remain unattainable to him. But I will create a conscious happiness in his mind." Ibsen's suggestion of a conscious happiness is essential for a well balanced personality. The subconscious streams of life that nourish activity are not to be disregarded. Little Eyolf's conscious realization of his relative impotence was less significant for his growth and comfort than those ever present accumulating emotions striving for expression through his hampered body.

SUBCONSCIOUS INFLUENCES

The influence of the subconscious elements is easily noted in the traumatic neuroses or the hysterias following accidents and operations, that are as productive of invalidism as a paralysis due to embolism. Alterations in personality consequent on accidents, and acquired disabilities, are by no means more significant than those distortions arising from congenital deformities, or from the physical maladjustments that result from industrial accidents or ultrahazardous adventures during youth. A physical defect, congenital or acquired, is a challenge to personality in its development. The physical basis of deformity is not to be regarded as an injury only to the body. The interferences with function, the thwartings of desires and the handicaps to normal self-expression, profoundly affect life in all its phases. The useless arm or leg impairs mental function, though not to the same extent after a fracture as would obtain following an apoplexy. The cleft palate and harelip, with the modification of natural appearance and their influence on voice, have a more definite influence on the mode of thought, sentiments, judgments and social adjustments than almost any disease that flesh may suffer. It requires a vigorous type of person to surmount the difficulties overcome by the misshapen Steinmetz. It is a man of rare personality that, with the severe deformity of Marshall P. Wilder, could stand before an audience and, with the appearance of genial adjustment, remark, "I am a self-made man." Man's power of adjustment is marvelous, and his ability to achieve a triumphant serenity, in the face of insuperable obstacles, is a part of man's sacred heritage. Certain forms of orthopedic disorder appear to be accompanied by character developments that create almost unlimited admiration, as for example, among those bedridden sufferers from arthritis deformans. One notes it not infrequently in the cheerful, hopeful, indomitable courage of children with tuberculous deformities. The personalities of those afflicted with honorable wounds, undergoes marked changes, until final normality is reached. But physical limitations or modifications may become crystallized in deteriorated as well as in improved states of adjustment; and fears, doubts, shame, obsessions, prejudices and despairs may destroy sound judgment and undermine stability of character.

REACTION OF THE AFFLICTED

Personality seeks to protect the self. It involves self-understanding, self-discipline and self-adjustment. It works through man's instinctive processes in order

to insure him satisfactions and comforts in life. Orthopedic defects frequently result in thwartings, disappointments and persistent limitations, with reactions that are bound to test out man's psychic resilience and his spiritual elasticity. There is a vast difference between consciousness of limitations and self-consciousness because of limitations. The sense of futility is a paralyzant force, while the retention of hope and encouragement is a stimulant to development.

The inherent basis of man's personality lies in his instinctive and emotional reactions, and they are expressed through his intellectual development and his social adaptations. Basically, all men desire to achieve success and to maintain independence, to secure power and to establish some dominance in life. Whatever interferes with these fundamental natural desires cripples man's activity. There may result modifications of personality along lines distinctly antisocial. Truancy, theft, vagrancy, anxiety and compulsive neuroses and, indeed, psychoses, may be the end-result of interference with the normal development of the self-serving ego instinct or the other elements of personality. What we were, as well as what we are, conditions our views, sentiments, opinions and actions; as expressed by Bergson: "It is with our entire past, including the original bent of our soul, that we desire, will and act." The dynamics of life involve constant adjustments that make, mar or alter man's nature. Physical handicaps bring about alterations in mental function, largely determined by their effects on man's emotional evolution. The emotions are the driving forces of life, and their modifications through orthopedic defects, or even orthopedic appliances, profoundly influence personality. Our views, therefore, of orthopedics must recognize the need of considering the total effects of involvements of bones and joints on intellectual, emotional and social life, with due recognition of the essential inherited trends for which it is difficult to fix responsibility. There is much justice in Robert T. Morris' broad view that "juvenile delinquents for the most part are not responsible, as they represent merely decadent traits or untrained good qualities." The delinquent is a person and, to a large extent, a creature of circumstances, despite the declaration of Disraeli: "Man is not the creature of circumstances, circumstances are the creatures of men."

Personalities, obviously, are of many types; two large groups are discernible. One, by nature, looks out toward the world and its realities, sees other people, respects their opinions and thrives in their companionship. The other type is bound up in self, focusing a spotlight for illumination on his own ideas, opinions and sentiments. The extravert is aggressive, powerful sociable, cooperative and dynamic to the point of trying to play a character part in the game of life, while the intravert is submissive and timid, struggling to be recognized as a bishop or a knight, when he is a pawn. Physical defects and their accompanying handicaps tend to throw individuals back on their own resources, and to lessen their effective social adjustment. Hence, in a sense, orthopedic defects conspire to produce introversion and social disorientation.

FUNCTION OF ORTHOPEDICS

It is the function of orthopedics to straighten deformities. The orthopedist primarily deals with pathologic states involving bones and joints, but, with every manipulation of his skilled conscientious hands, he is moving the material that constitutes personality. He who touches the flesh lays hands on the soul. It is unnecessary to stress the accepted relationships between sound physical health and moral purposes. From the moment of the primary examination until the patient is restored to a life of usefulness, the orthopedist is a factor in the patient's life. Every human touch brought to bear on the afflicted, under the direction and guidance of the orthopedist, is an influence molding a personality, and plays a part in the conscious and subconscious thinking of the patient. There are numerous responsibilities for anesthetists and nurses, occupational therapeutists and physiotherapeutists, follow-up nurses and teachers, whose goal is to secure the bodily restorations.

The efforts to secure anatomic replacement with attendant excellent cosmetic results is no longer deemed as essential as the attaining of the maximum functional restorations. It is time, however, to include the idea of psychic rehabilitation as an end and aim, because this includes ordinary functional rehabilitation and possesses a far larger concept of usefulness. The patient is to become a real person, with a personality fitted to take up the pleasures and pains of life with the maximum of normality. One should aid in the fight for cheerfulness, courage, enthusiasm and optimism, with initiative and independence, which everywhere constitutes the spirit necessary for complete life. Side remarks, words of sympathetic but pessimistic import, should not be voiced in the hearing of patients, unless they are meant to be heard and to serve as a basis for directing attention to a particular difficulty for which the patient's mind must be prepared, and whose results must be faced unflinchingly. Patients thrive on sympathy; but if that is all they receive, they may be killed by the kindness. Understanding, redirection, education, encouragement and moral support are far more vital for securing or maintaining the proper view of life. The tonics, iron, quinin and strychnin do not possess the values of stimulative action that may be found in a patient, genial smile, a hearty word of encouragement, or praise at efforts to do better today than was done yesterday.

Physical handicaps profoundly affect mental function, particularly when mental adjustment must be made for physical activity as well as for intellectual efforts. The right handed person who has lost the use of his right hand and must begin a left handed attack on life and industry has lost more than his right hand. His physical impairment may be rated by a compensation commission, but there is no method of establishing the damages for the complete alterations of his psychic functions, including his intellectual limitations, his emotional struggles and his industrial reapplication. Orthopedic service now gives recognition to the values of occupational therapy, but the earlier bodily reeducation is begun, the more favorable is it likely to be in its effect on the personality. Prompt reeducation is essential, gradually guided into special training to meet individual needs, and functional adaptation is the goal. There should be no break in the continuity of personality guidance; there should be no opportunity for the growth of a sense of futility or a willing acceptance of, or a resignation to, a loss of place in active, dynamic living.

The orthopedic result should be the promotion of social thinking and social action. The cripple is a creeper, and he must be taught how to walk. So far as possible, he should be relieved of the necessity of depending on supports; his physical body should be relegated to a subordinate position in his life. Health in its highest form is without consciousness of the existence of a body as a whole or of any of its members

or viscera. It is enervating for man to be enslaved by a portion of the body of which he should be master.

According to the definition applied in the English census of 1911 in Birmingham, a cripple is "a person whose (muscular) movements are so far restricted by accident or disease as to affect his capacity for self-support." Obviously, the necessity of independence is recognized. There are, however, many who are capable of self-support, but nevertheless, are psychically crippled. There are probably 250,000 cripples in the United States, but there is little evidence to indicate their states of mind, much less to have a complete story of their struggles with themselves and with the world for the necessities of life, and the barest essentials for comfort and happiness.

The orthopedist should develop a deeper interest in the recreational and functional adaptations that are essential for social adjustment. His sphere of activity should at least involve some familiarity with the mental potentials of his patients, their interests and aptitudes, their physical and emotional limitations, in order that he may have intelligent ideas concerning their possible earning power, and the methods best suited to lead them back to self-direction, self-support and self-respect.

There are marked distinctions between the effects of the curable and the incurable disabilities of accident or disease. For some, an anatomic restoration that will conceal the defect may conserve personality, whereas, a functional restoration, with obvious anatomical ugliness, would still leave them discontented, self-conscious and isolated. For some, the consciousness of incurability serves as a powerful stimulant to greater effort, while for others, it is a depressant and oftentimes a paralyzant to purposeful effort.

One must bear in mind at all times the dangers of institutionalism, and there should be definite effort to minimize the time spent within hospital walls. The greater freedom of a convalescent home, with opportunities for normal recreation, occupation and companionship, is more sustaining to the spirit. There is a definite advantage in personality development under home conditions. It is always harmful to prompt segregation, save for purpose of education. Differences should not be accentuated, but likenesses merit emphasis to promote human relationships.

SOCIAL ADJUSTMENTS

Every injury or deformity involves adjustment, whose success depends on inherent and developed spirit, temperament and attitudes toward life. Any bodily weakness may serve as the background for the development of a weak personality and a poor character. The defect in itself may not directly be responsible for personality deviations that result, for example, in delinquency. Antisocial tendencies among children may arise as the result of exclusions from school, recreation and companionships; the limitations of occupational activity, and the thwartings of desire for adventure, excitement, play and friendships. Tendencies toward self-pity may easily lead to withdrawal from the realities of life, and may induce day dreaming, fantasy and neurosis. A broken body favors a broken spirit. One has an opportunity to note some of the effects of disabilities on personality by a consideration of certain parasitic types, such as tramps, beggars and criminals. Mrs. Solenberger, in her investigation of 1,000 homeless men, found 254 of them to be temporarily or permanently crippled or maimed. This, obviously, is a far higher percentage than obtains in society as a whole. Five of these men were born cripples, 163 were maimed through accidents, of which fifty-five occurred in industry. Eighty-six of the group owed their physical handicaps to distinctly medical diseases, such as rheumatism, locomotor ataxia, gonorrhea, tuberculosis and amputations for nontraumatic causes. The degree of dependence is well evidenced in the fact that very few of the 254 were at the time capable of self-support.

It is obvious that there is a tendency for people to seek the easier way when their full power is decreased. Hence, there arise tendencies toward sneakiness, dishonesty, indolence and actual withdrawal from moral realities. Begging is highly remunerative, but the beggar is a social parasite. With the high development of artificial limbs and with the increased understanding and use of vocational reeducation, there is little excuse for persons to remain incapable of performing some useful service, and through it of maintaining a reasonable satisfaction with self and life.

Our prisons hold a fairly large proportion of inmates with physical defects, but the relative proportions do not differ greatly from those found in the general population. It is difficult to state, with scientific certainty, the part that orthopedic defects may play in the development of abnormal antisocial impulses that lead to crimes, whether they be of violence, force or sex assaults. There are many types of persons who become delinquents without any orthopedic defect. But it is equally certain that the physical handicap may serve as the lever to move a weak personality down a plane leading toward antisocial activity. Robert T. Morris has referred to a type of delinquents who become so because "their parents were allergic to microbe poisons." But these are by no means as numerous as those who are subject to the toxic influences of self-suffered handicaps. Without generalizing in the least, one may say that many persons become delinquent, defective, dependent, either singly or in combination, by reason of physical deformities that limit their development, interrupt and often disrupt their occupation, and strangle or mutilate their success. Antisocial activities that arise from abnormal personalities are readily understood psychologically, because man tends to act in harmony with his inheritance, his development, his opportunities, his fixed habits of body and mind, and his application and social contacts.

One cannot predict with certainty the results of orthopedic handicaps, manipulations or corrective apparatus. An armless man, by force of character, developed through patient education and training, rose triumphantly above his disability. A young boy with a cleft palate, after finding the taunts of companions unendurable, dared to fight his way to successful living, and became a champion pugilist; but with a very profound discontent, due to his handicap, he became the victim of an incapacitating neurosis. A young woman, whose cured tuberculous hip resulted in a shortening of her leg, centered her life, thoughts and activities on her handicap, so that her personality was twisted, and every outlook of life was filled with gloom. A child with equinovarus, unable to participate in the ordinary games and plays of children, sank back isolated, depressed and overpowered by a sense of inferiority, and of the gross futility of childish existence. I need not specify the innumerable types of orthopedic defects that cramp and distort personality. I merely wish to point out that the highest plane of orthopedic efficiency cannot be

achieved without due recognition of the influence constantly brought to bear by orthopedists.

THE ORTHOPEDIST

The orthopedist is more than a surgeon or a corrector of deformities. He is a real personality who, by direct and indirect suggestion, is constantly working on the conscious and subconscious elements in the lives of his patients. He is a social agent to the extent that he sees his clientele, not merely as individual sufferers, but also as potential participants in active social life. It is part of his function to restore the bodily errors, but even more, to guide, direct and counsel the mind, so as to conserve for society those factors that contribute to vigorous, stabilized personalities. Functional restoration is his goal, but it is such in the sense of a true functional restoration of a person and not of a part. Personality is the foundation of character, and character develops as the result of interaction of a man and his environment. The orthopedist should appreciate the influences of both as fundamentals in enabling man to realize his maximum potentials for helpful, hopeful, energetic, practical and vital life.

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CONGENITAL DISLOCATION OF THE HIP

A CLINICAL STUDY OF TWENTY-NINE CASES *

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I have collected the histories of the patients with congenital dislocation of the hip seen at the orthopedic department of the Stanford clinics during the last few years, and to them I have added my own.

DETAILED REPORTS

CASE 3.—Oct. 4, 1915, the Lorenz operation was done. The left hip was reduced; the right hip, not. December 6, an open operation on right hip was done. The patient died that night from hemorrhage.

CASE 12.—Nov. 23, 1914, the Lorenz operation was done on both sides; good stability was obtained on the right; poor, on the left. One hip slipped out and was operated on later in another hospital. The child cannot be found for examination.

CASE 16.—May 16, 1914, the Lorenz operation was done on both sides. August 4, the right head was in; the left head, out. A second attempt with the Lorenz operation was made on the left hip, the hip being put up in extreme internal rotation. The right head slipped out and was reduced, December 11. This resulted in failure. Jan. 23, 1915, roentgen-ray examination showed the left head still in place. March 15, an open operation was done on the right hip through an anterior incision. The head of the femur seemed rather flat; the neck had the so-called anterior twist, and the capsule had a tight constriction. The last was slit up with a bistoury, and the head was then easy to replace. Plaster of Paris was applied with the hip in extreme internal rotation. June 4, an open operation was started on the left hip, which had slipped out. When the incision had been carried down to the capsule, the child's condition was so bad that the wound was sewed up quickly. August 26, roentgenograms showed the right hip in place. December 10, the head of the right femur was slightly upward, and of the left femur more so. The hips then became rather stiff in abduction. This abduction did not yield to manipulation. The Soutter operation was done later on both sides. Jan. 16, 1917, both femur heads were out of place. March 15, 1925, the patient could not be found.

CASE 20.—The neck of the left femur had the so-called anterior twist. Nov. 2, 1923, a Lorenz operation was done on both sides. Jan. 7, 1924, left subtrochanteric osteotomy, and rotation of the distal fragment outward, were done. Plaster was left on for six months. March 4, 1925, there was no limp. The left thigh was in slight external rotation. Internal rotation was slightly limited. Roentgen-ray examination showed the heads in place.

CASE 21.—Jan. 8, 1917, a Lorenz operation was done on the left hip. June 15, an open operation was done through an anterior incision. A constricted capsule was found, which was dilated, and slit. July 22, 1919, a Lorenz operation was done on the right hip. A mild case of Legg's disease developed later; July 30, 1920, the hips were put up in plaster in extreme abduction. This plaster was continued one year. March 17, 1925, there was no limp or peculiarity in the gait. There was free motion. Roentgen-ray examination showed the heads in place.

Outline of Histories

Case	Sex*	Age Years	Hip	Treatment	Result
1	♀	2½	Right	Lorenz operation	Cure (seen 10 years after operation)
2	♀	3	Double	Lorenz operation	Cure (seen 12 years after operation)
3	♀	14½	Double	†	Death
4	♂	16	Right	Lorenz operation	Failure
5	♀	2	Left	Lorenz operation	Cure (seen 6½ years after operation)
6	♀	11	Double	Refused treatment	
7	♀	7	Double	Refused treatment	
8	♀	23	Double	No treatment	
9	♀	8	Double	Refused treatment	
10	♀	2½	Left	Lorenz operation	Cure (seen 9 years after operation)
11	♀	2½	Double	Refused treatment	
12	♀	4	Double	†	
13	♀	..	Double	Refused treatment	
14	♀	16	Right	No treatment	
15	♀	1¹/₁₂	Left	Refused treatment	
16	♀	3½	Double	†	Failure
17	♀	1¾	Right	Lorenz operation	Cure (seen 2 years after operation)
18	♀	2¼	Left	Refused treatment	
19	♀	1½	Right	Refused treatment	
20	♀	2	Double	†	Cure
21	♀	2	Double	†	Cure
22	♀	8	Double	†	Under treatment
23	♀	10	Double	†	Failure
24	♀	5	Right	Lorenz operation	Cure
25	♂	2	Right	Refused treatment	
26	♀	2	Left	Lorenz operation	Cure †
27	♀	3	Double	†	
28	♀	1½	Left	†	Cure
29	♀	10	Double	†	

* In this column, ♂ indicates male; ♀, female.
† Described in the detailed reports.

CASE 22.—June 20, 1924, a Lorenz operation was done on both sides. Jan. 16, 1925, both heads were out of place and the hips were rather stiff. January 19, an open operation was done on both hips through an anterior incision. The head of the femur on each side looked directly forward. The capsule was greatly contracted and was adherent to the head of the bone, and the heads were irregular in shape. March 17, roentgen-ray examination showed the heads of the femurs in place. March 20, a subtrochanteric osteotomy was done on both sides, with rotation of the distal fragment externally about 90 degrees.

CASE 23.—A Lorenz operation had presumably been done seven years before. Nov. 23, 1915, a Lorenz operation was done. Neither head could be replaced. Complete paralysis of the extremities, sensory and motor, followed the operation. Jan. 18, 1916, an open operation was done on the right hip. The neck of the femur was fractured. Suppuration followed, and the head of the bone was evidently absorbed. Paralysis slowly cleared up. March 5, 1925, the patient was able to go about fairly well, and was said to be quite vigorous.

CASE 26.—May 4, 1921, a Lorenz operation was done. Feb. 27, 1922, there was a slight limp and considerable limitation of motion; the head was in place; the lower extremity on the operated side was 0.5 cm. longer than the other. In March, 1925, the patient could not be reached for examination.

* Read, with demonstration of cases, before the San Francisco County Medical Society, March 17, 1925.

CASE 27.—Jan. 9, 1923, a Lorenz operation was done on both sides. It was a failure. July 17, an open operation was done on both sides through an anterior incision. The heads were found directly forward. The capsule was opened, slit and dilated. On the right side, the constriction of the capsule was tight. Dislocations were reduced. December 4, a subtrochanteric osteotomy was done on both sides, with rotation of the distal fragment externally about 90 degrees. Sept. 30, 1924, roentgen-ray examination showed a well marked Legg's disease in both hips. In March, 1925, the patient could not be found.

CASE 28.—April 26, 1923, a Lorenz operation was done. There was poor stability. The operation was a failure. June 4, an open operation was done through an anterior incision. The capsule was opened, slit and dilated. The head of the bone was anterior. Plaster of Paris was applied with the thigh in extreme inward rotation. August 14, a steel nail was driven into the trochanter, and subtrochanteric osteotomy was done. The distal fragment was rotated out about 90 degrees. Plaster of Paris was continued until Nov. 26, 1923. Feb. 18, 1925, there was a complete cure; the heads were in the sockets. The lower extremities were of equal length.

CASE 29.—May 2, 1924, a Lorenz operation was done with the employment of a wedge. There was failure on both sides. The operation was followed by complete sciatic paralysis, sensory and motor, on both sides. This slowly improved, and had almost disappeared eleven months later.

COMMENT

Of the twenty-nine patients, of whom twenty-seven were female, and two male, ten refused treatment, two of whom we learned were treated elsewhere. The proportion of girls to boys, 93 per cent., is greater than the usual 80 per cent.

In six cases the dislocation was on the right side, in six cases on the left, and in seventeen both hips were out of place.

The treatment adopted in all the cases was that of Lorenz, by manipulation without incision, followed by plaster of Paris in extreme abduction for varying lengths of time. When this was unsuccessful, an open operation was done. In seven cases the Lorenz operation was successful, and in one hip of each of two double cases. The only untoward result of the operation was sciatic paralysis, which occurred in two cases of double dislocation, both in girls, aged 10 years. Neither paralysis was permanent, though in one it was still partly present when last seen, about nine months after the operation. I believe that it was caused in each instance by the Lorenz wedge, which was employed in the attempt to lever the heads into the socket.

When the Lorenz operation failed, we usually resorted to open operation without a second attempt at manipulation, and we invariably found that when we made a second attempt by manipulation the attempt was a failure. Operation showed that the failure in almost every case was due to one or both of two things: (1) constriction of the capsule with or without adhesion to the femoral head; (2) the so-called twist of the femoral neck, which is more probably an internal twist of the shaft of the femur. Deformities of the acetabulum played a minor rôle. In one or two cases, roentgen-ray examination showed how nature could build up a deficient proximal lip of the acetabulum if the head of the bone was put back into place and kept there.

In operating, the incision chosen was the anterior one, carried down between the tensor fasciae latae and the sartorius. When the capsule was reached, it was opened widely, and any adhesions between it and the head of the femur were divided. The finger thrust into the capsule detects any constriction of it. Often the capsule is so constricted that the finger cannot be passed into the acetabulum. The constriction should be thoroughly divided, with the edge of the knife directed distally to avoid troublesome hemorrhage. A uterine dilator helps to stretch the capsule. In those cases with anterior twist of the neck, the head of the femur may present directly forward in the wound. Before sewing up the wound in layers, the operator assures himself, by manipulating the thigh, that there is no obstruction to the return of the head into the socket. In simple cases of capsular causation, the plaster of Paris reaches only to the knee, with the thigh in moderate abduction and slight flexion.

In cases complicated by an anterior twist of the neck, the head is directed forward, and the displacement is directly proximal, instead of proximal and backward. In order to reduce the dislocation, the femur must be rotated sharply inward, and in order to hold the femur in internal rotation, the plaster must be extended down the leg, with the knee in flexion for the purpose of leverage. This is an awkward position, but is necessary. Now, if nothing else be done, when the plaster is removed, the patient, in order to direct the foot forward in walking, must rotate the femur outward again. In doing this she simply turns the head forward again out of its socket, and we are back where we started. I believe that it was Sprengel who first found a way out of this difficulty. The method is briefly as follows:

After the hip has been in plaster for a month or two, with the thigh in marked abduction and slight flexion, the plaster is removed. An assistant is assigned to maintain the internal rotation while the field is prepared for operation. Then the patient is immediately anesthetized, and a steel nail is driven into the great trochanter. A short longitudinal incision is made on the lateral aspect of the femur at the level of the lesser trochanter, and an osteotome is pushed down to the bone, dividing the perioseum. The osteotome, turned transversely, divides the bone. Now, with the assistant holding the proximal fragment by means of the nail, the operator rotates the distal fragment sharply outward, so that the leg, instead of pointing backward, lies in about the plane of the body. A few skin stitches close the two small wounds. The nail protrudes through the sterile dressing, and a small window, cut in the plaster, permits the withdrawal of the nail in a few days. Hibbs recommends an osteotomy a short distance proximal to the knee, instead of a subtrochanteric osteotomy, and possibly his procedure is the logical one. After the plaster is removed there is no reason for the patient to rotate the femur outward, for we have already rotated it for her. Indeed, if we have carried the rotation somewhat beyond the degree that seems necessary, the patient is compelled to use forced internal rotation to walk properly. She thereby makes the reposition more secure. It is rarely necessary to keep these hips in plaster more than four or five months. Some stiffness often is present, in the sense of fixed abduction, when the plaster is removed, but this slowly wears away.

Four of our patients were treated by the operation without osteotomy. One, aged 14½ years, died of a postoperative hemorrhage. In one case the operation was a failure in both hips. In the third it was a success in both. In a fourth, on one hip of a double case in a girl, aged 10, I broke the neck of the femur. This also was a failure.

In four cases the capsular operation was followed by subtrochanteric osteotomy, two single and two double. Two of the cases are a complete success. One of the patients is still in plaster. In the fourth case the hips remained in place, but a typical case of Legg's disease

was developing when the patient was last seen, one year after operation. We have noticed this tendency to Legg's disease and subsequent coxa vara in two or three of our patients. Its occurrence lends support to the view that Legg's disease is a developmental anomaly, probably caused by some interference with the blood supply to the head of the femur. It can be treated quite satisfactorily by prolonged immobilization in plaster of Paris, in extreme abduction. We attain the extreme abduction by manipulation under ether.

The high percentage of patients who refused operation is worthy of note. In a number of cases we went out of our way, through our social service department, to obtain the parents' consent. Operation in young patients can be urged with very little risk. Our only disasters occurred when we employed too severe methods in older patients. When one starts, one hates to give up. This is a mistake.

In a general way, in young patients, one can gage one's prognosis by the development of the head. If this is approximately normal, a good result may be expected. Ordinary obstructions can be overcome. We like to undertake the operation as soon as the child has been broken of the diaper. Before that time it is hardly worth while. The plaster is ruined in a few days.

The length of time the patient remains in plaster varies with the stability of the reposition between about six months and a year. In the closed operation, the hip remains in extreme abduction for three or four months, and in an attitude of modified abduction and slight reflexion for somewhat longer.

VALUE OF CHLORIN IN THE TREATMENT OF COLDS *

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Few announcements in recent years have occasioned more hope in the minds of the medical profession and the laity than did the report on chlorin as a therapeutic agent in certain respiratory diseases made by Vedder and Sawyer [1] about a year ago. Although usually considered trivial, acute colds cause more disability and loss of time from work and school than the more serious diseases.

Recently, Dr. Taylor-Jones [2] reported that more than one fourth of the absences of 3 A grade children in Washington were due to "common colds," and Dr. Collins,[3] in the study of morbidity among school children in Hagerstown, Md., found that about one third of the cases of illness in school children are due to colds, and that in a school year of 180 days the average amount of time lost per child on account of colds was 1.86 days. At the University of Minnesota, during the winter months, we find that from one fifth to one third of the calls made at the dispensary of the Students' Health Service are on account of colds. Other universities, as well as industrial organizations, probably have very similar rates.

Acute respiratory infections universally form the biggest problem with which health services have to deal; so, when Vedder's report appeared, we at once got in touch with him and with the Wallace and Tiernan Company which supplied the equipment that he used. This company kindly offered to send us an equipment similar to Vedder's which we could use for experimental purposes. We hoped to procure further evidence as to the value of this treatment, and believed that we had unusual opportunities for so doing, because in the student body we have a large, intelligent and cooperative group, which every year is affected with many acute respiratory infections.

APPARATUS USED

For the giving of the chlorin treatments, a small room, 10 by 8 by 8½ feet, was used. The walls and ceiling were given several coats of paint to prevent absorption of the gas. The chief part of the apparatus was a motor driven air blower, which, through a hole in the wall, blew warm air from a corridor into the room. A venturi tube measured the volume of air passing through the blower. The chlorin gas was contained in a cylinder, and, after passing through a siphon meter, was mixed with the air as it passed through the blower. Knowing the volume of gas discharged with each pulsation of the siphon meter and the volume of air passing through the blower, it was possible to calculate the rate at which the siphon meter should discharge, to give any desired concentration of chlorin in the atmosphere of the room. The siphon meter used had a capacity of 11.3 c.c., at 7 pulsations per minute. The pump was operated at a rate of 500 or 600 cubic feet of air per minute. At 500 cubic feet, the siphon meter had to discharge once every nine seconds to give a concentration of 0.015 mg. of chlorin per liter of air, and once every eight seconds to give a concentration of 0.0175 mg. The timing was done with a stop-watch, and the concentration kept between 0.015 and 0.0175 mg. per liter. A quantitative analysis made of the air during operation showed that the actual amount of chlorin in the air varied less than 5 per cent. from the calculated concentration.

While treatments were being given, a small window at the opposite side of the room from the air blower was opened to permit the escape of air. The room had a capacity of about 680 cubic feet, so that, with the blower operating at the rate of 500 cubic feet per minute, the air in the room was completely changed in less than a minute and a half. Tests made with matches and with cigaret smoke showed that there was no stagnation of air at any part of the room. Not more than eight students were allowed in the room for treatment at one time, although, with the rapid change of air, a larger number doubtless could have been treated without materially affecting the concentration of the gas.

METHODS OF TREATMENT AND REPORTING

The Students' Health Service maintains a dispensary to which students may come for medical advice and treatment. When the chlorin treatments were well established and the collection of data begun, the following bulletin was sent to the physicians on the staff:

Inasmuch as the Students' Health Service is prepared to give the chlorin treatment of colds a thorough trial, physicians who see students with colds are requested to observe the following procedure:

1. Classify each acute respiratory infection according to the portion of the respiratory tract involved; e. g., acute rhinitis,

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* Read before the Minnesota State Medical Association, April 28, 1925.

† From the Students' Health Service and the Department of Preventive Medicine and Public Health, University of Minnesota.

1. Vedder, E. B., and Sawyer, H. P.: Chlorin as a Therapeutic Agent in Certain Respiratory Diseases, J. A. M. A. **82**: 764 (March 8) 1924; The Treatment of Certain Respiratory Diseases by Chlorin, ibid. **84**: 361 (Jan. 31) 1925.

2. Taylor-Jones, Louise: Causes of Absence in One Grade of Fifteen Public Schools in Washington, D. C., Pub. Health Rep. **39**: 2345 (Sept. 12) 1924.

3. Collins, S. D.: Morbidity Among School Children in Hagerstown, Md., Pub. Health Rep. **39**: 2391 (Sept. 19) 1924.

tonsillitis, pharyngitis, laryngitis, tracheitis, bronchitis or any combination of these.

2. Note on the dispensary record the number of days that the cold existed before the student reported.

3. In order to have a satisfactory control series, select for the chlorin treatment alternate cases of those who request health service care. In case a student specifically requests the chlorin treatment, he should be permitted to take it, and the next case given other treatment as a control.

4. Students who are to receive the chlorin treatment should have, in addition, any other medication which seems indicated.

5. Results cannot be expected from the chlorin if the paranasal sinuses or the crypts of the tonsils are infected, so such cases should not be referred for chlorin treatment.

6. If there is any history of asthma, the student should not be given the chlorin treatments.

At the chlorin room, a record of all treatments was kept by a nurse. This included the patient's name, the diagnosis, the day of the disease and the number of treatments. The treatment given was one hour in duration, except when the chlorin seemed to cause

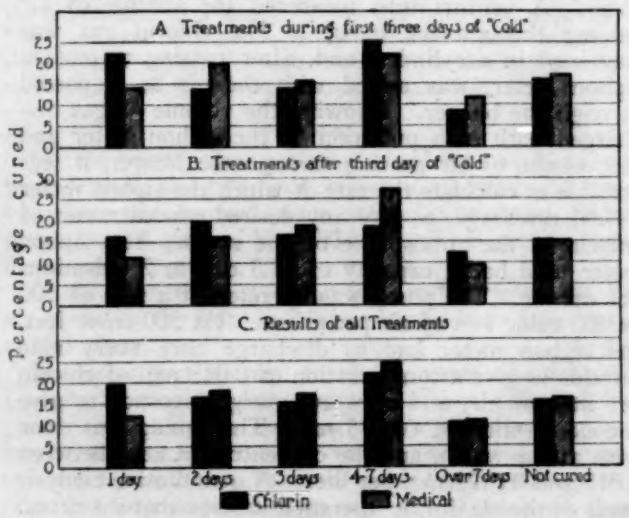

Chart 1.—Summary of results.

severe irritation. On the wall of the treatment room, the following notice was posted:

In order to get good results from the chlorin treatment, it is frequently necessary to take two or three treatments on successive days; so, if your cold is not cured after one treatment, return for more.

Please note the effect which this treatment has upon your cold and report this to us on a card which will be mailed to you in about a week.

At the end of a week, a card containing the following information and questions was mailed to each student:

The Students' Health Service is making a study of the effect of the various forms of treatment on colds. Our records show that you have recently been afflicted with a cold: hence you are requested to assist us in this study by filling out this card and returning it through the university mail.

1. What was the duration of the cold in days before treatment?

2. What was the duration of the cold in days after treatment?

3. In your opinion was the treatment beneficial?[4]

No examination was made of the patients subsequent to the treatment, because there are no definite objective criteria by which one can judge whether a cold has improved or not. The patient's opinion about his condition, of course, is subject to considerable variation and inaccurary, but in a large series the error due to individual differences would be reduced to a minimum; and certainly two large series should be comparable.

4. The third question was included only on the cards sent out after Jan. 1, 1925.

CONTROL SERIES

Each day, the clerk who had charge of indexing diagnoses chose at random, from the names of the students who received medical treatment for colds, a number of names that corresponded to the number given chlorin treatments on that particular day. To these students, the same card was mailed as to those who were given chlorin treatments.

The medical treatment given to this control series was not in any sense uniform. Some received laxatives, some antipyretics, some rhinitis or coryza tablets, some cough mixtures, some gargles, some inhalations, some nasal oil, some various combinations of these and some nothing.

RESULTS

All report cards that were satisfactorily filled out were tabulated according to diagnosis, treatment, age of cold when treated, and length of time before recovery. In the series studied, 425 students were given chlorin treatment, and 392 given medical treatment or no treatment. The percentages of patients cured with chlorin in one to three days and one to seven days differ but little from the percentages who recovered in the same time under medical treatment. Separate tabulations were made of the results obtained during the fall months October, November and December, and the winter months January, February and March, but the variations were of minor importance and inconstant.

A summary of the results of the chlorin and the medical treatments, irrespective of the diagnoses, are shown graphically in Chart 1. Of the total that were treated with chlorin, 51.4 per cent. reported themselves cured within three days, while 47.9 per cent. of those given medical treatment recovered in the same time, showing practically no difference. There was still less difference between the percentages that recovered under chlorin and medical treatments during the first week, 73.3 and 72.6 per cent., respectively.

However, the percentage of cures within the first day is consistently higher with chlorin than with medical treatment. The difference is most marked if the colds are treated within the first three days, but the percentage of cures with chlorin is also higher for colds treated after the third day, and for the total number treated. The beneficial effects of chlorin evidently are experienced within the first day after the treatment, because each day after the first the percentage of recoveries is higher from medical treatment than from chlorin. This, of course, is not surprising, because the effect of the chlorin gas on the tissues is local and temporary.

Various Types of Colds.—The classification of colds according to the part of the respiratory tract involved needs no explanation. No such classification, of course, is accurate, because a cold may be a rhinitis today, a rhinitis and pharyngitis tomorrow, and a tracheitis and bronchitis a few days later; but some of these infections tend to remain more or less localized in one part of the respiratory tract. Cures could be attributed to chlorin only if they occurred within the first day after treatment; consequently, only the percentages cured in one day need to be compared. The results are better in cases of rhinitis than in any other type of cold. This is true of the cases treated during the first three days,

those treated after the third day and the total treated. The control series shows that, with medical treatment, the largest percentage of recoveries in one day occurred in the acute respiratory infections not limited to one area.

Results of Treatment at Various Stages of the Disease.—Every one who has advocated the use of chlorin in the treatment of colds has advised that the earlier the treatments are given the better the results obtained. Chart 2 illustrates the percentage of cures in one day. It is evident that we obtained the largest percentage of cures with chlorin when the treatments were given on the second or third day of the disease.

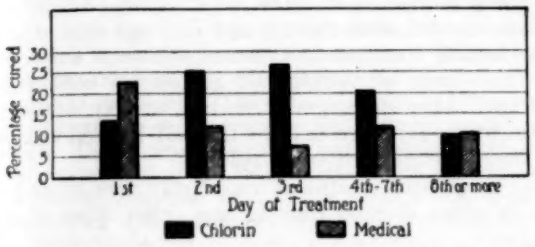

Chart 2.—Results according to day of treatment.

Medical treatment, on the other hand, gave the largest percentage of recoveries in one day when the treatment was given on the first day of the disease, the total cures in one day, however, were greater with the chlorin than with medical treatments.

Multiple Treatments.—The percentage of students who are cured by two or more treatments varies but little from the percentage cured with one treatment.

Patient's Opinions of the Treatment.—The question asking the patient's opinion as to the value of the treatment was included only during the latter months of the study, so the number of replies is relatively small, 133 students who had chlorin, and 153 students who had medical treatment replying to this question. Many students expressed themselves enthusiastically in favor of the chlorin treatment, but a large percentage of students also felt that they were benefited by medical treatments.

Whooping Cough.—During the summer of 1924, when the university was not in session, eight cases of whooping cough, six in children and two in adults, were treated. From six to twelve treatments of an hour each were given on successive days. One adult and four children were reported as definitely improved, the paroxysms of coughing and vomiting decreasing in frequency and severity. The effect on one adult and one child was doubtful, and one child was reported as unimproved. This series, although somewhat interesting, is too small to be of value, particularly as there were no controls.

Diphtheria Carrier.—One convalescent carrier of diphtheria bacilli was given three treatments on successive days, but the cultures remained positive.

Ill Effects of the Treatments.—In our experience, demonstrable ill effects from the chlorin treatments have been negligible. Many of the patients experienced some irritation of the throat for several hours after the treatment, but this effect was only temporary. A few reported that the chlorin caused headaches, coughs or sleepiness which lasted from several hours to several days. However, since we know that colds in themselves may cause all these symptoms, it is doubtful whether the chlorin should be blamed in these cases. Four patients who were subject to asthma insisted on trying the chlorin treatment in spite of advice against it. In each instance, an acute attack of asthma followed. One patient who had chronic bronchitis, but gave no history of asthma, was confined to bed for several days with an acute attack of asthma as the result of one hour's treatment. This patient, of course, should not have been allowed to take the chlorin treatment.

COMMENT

The treatment of colds is a subject on which medical literature contains a host of diametrically opposed opinions. Some authors recommend complete rest;[5] others recommend exercise;[6] some advocate the giving of cathartics;[7] others do not;[5] some attempt to stimulate secretions of the nose and throat from the beginning of the cold;[6] others to dry them up;[8] some believe vaccines will prevent colds; others doubt their value; and so on. In reviewing the writings on this subject, however, one is impressed with the few tabulations of results and the almost complete absence of comparisons with control cases. Sholly and Park[9] compared the incidence of colds over a period of six months in a large group of persons who were given "cold vaccines" with the incidence in an untreated group. Their findings were that colds were more frequent in the vaccinated than in the unvaccinated group. Macdonald[10] recently compared the results of treatment with and without cathartics in a small series of persons with acute colds. He found that the disability of persons who had been given cathartics was longer than the disability of those who had not. These few reports illustrate the necessity of having a control series in any study of the treatment of colds.

The method of administering the chlorin in this series of treatments was such as to assure a definite and constant concentration of chlorin in the room, and unquestionably we had a more accurate and constant concentration than could be obtained with any of the various types of apparatus on the market, from which at first a calculated amount of chlorin is liberated into a closed room, and then smaller amounts liberated in thirty or forty-five minutes to make up for the amount lost in that time.

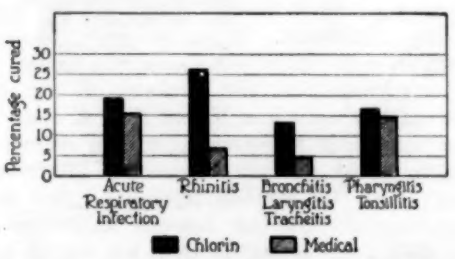

Chart 3.—Cures in one day of various types of colds when treated during the first week.

The medical treatments given to the students in this series were chiefly symptomatic, and we have no evidence that just as large a percentage would not have recovered in the same time without any treatment whatever. In fact, in this series so many different kinds of

5. Fantus, Bernard: Therapy of Catarrhal Fevers, J. A. M. A. **75**: 1694 (Dec. 18) 1920.
6. Heath, O.: Natural Cure of the Common Cold, Lancet **1**: 688 (April 8) 1922.
7. Osborne, O. T.: The Etiology and Treatment of Colds, New York M. J. **109**: 529 (March 29) 1919. Cecil, R. L.: Common Cold, Its Prevention and Treatment, M. Clin. N. Am. **8**: 103 (July) 1924.
8. Osborne (Footnote 7).
9. Von Sholly, A. I., and Park, W. H.: Report on the Prophylactic Vaccination of 1,536 Persons Against Acute Respiratory Diseases in 1919-1920, J. Immunol. **6**: 103 (Jan.) 1921.
10. Macdonald, Hugh: Catharsis in the Treatment of Colds, J. A. M. A. **80**: 1375 (May 12) 1923.

treatment were used that it certainly is more accurate to speak of the recoveries under medical treatment than of the cures from the treatments. Likewise, of course, many of those who took the chlorin treatments probably recovered rather than were cured.

The results that we obtained are not so good as we had hoped they would be, but they are not completely disappointing and certainly not so absolutely negative as those reported by Harris [11] of the New York City Department of Health. It appears from the tabulations we made that the beneficial results from chlorin are limited to the first twenty-four hours after the treatment, so our comparison should be between the percentage of recoveries in one day with the chlorin treatment and the percentage in one day with medical treatment. In the group as a whole, we find 19.5 per cent. recovered in one day with chlorin, and 12.5 per cent. recovered in one day with medical treatment, more than half again as many recoveries in one day with chlorin as with medical treatment. Of the patients with rhinitis, the type of cold with which we obtained the best results, we find 23.6 per cent. recovered in one day with chlorin, and 6.7 per cent. recovered in one day with medical treatment, three and a half times as many with chlorin as with medical treatment. In the acute colds, that is, those treated during the first week, immediate recoveries are persistently and definitely more frequent with the chlorin than with the medical treatments (Chart 3).

It is difficult to compare our results with those of Vedder [1] or of Gilchrist,[12] because they do not state in what length of time patients were considered as cured; e. g., Vedder reports that of his total series 71.4 per cent. were cured, 23.4 per cent. improved and 5 per cent. unimproved. If "cured" means within one day, our results are much lower than his; but, if "cured" means within a week, our figure of 73.3 per cent. is very close to his; of course, one should keep in mind the fact that we found 72.6 per cent. recovered within the same period under medical treatment.

The observations that during the influenza epidemic the soldiers working in chlorin plants did not get influenza is very significant. It is, however, much easier to believe that daily exposure to chlorin would destroy infective organisms on the surface of the mucous membrane of the nose and throat than it is to understand how exposing the surface of the membrane to chlorin gas would destroy organisms after invasion has taken place. Of course, it may be that in colds no actual invasion of the mucous membrane takes place; in that case, it seems that we might hope to effect cures by such treatments.

Since the results in this series have been at least encouraging, the treatments and observations will be continued.

SUMMARY

1. Most opinions as to the value of the various forms of treatment for colds have been made without careful analyses of results and comparisons with control series.

2. In this study, the results of the chlorin treatment of 425 students with colds are compared to the results of the medical treatment of 392 students.

3. It seems that the beneficial effects from the chlorin treatment are all experienced within the first day after the treatment.

4. The percentage of patients who recover within one day with the chlorin treatment is definitely higher than with the medical treatments; 19.5 per cent. of those having chlorin and 12.5 per cent. of those having medical treatments recovering in one day. Of the group with acute rhinitis, 23.6 per cent. of the ones treated with chlorin and 6.7 per cent. of those with medical treatment recovered within one day.

5. Of the entire series, 51.4 per cent. of those treated with chlorin and 47.9 per cent. of those given medical treatment recovered in three days; while 73.3 per cent. of those treated with chlorin and 72.6 per cent. of those with medical treatment recovered within a week.

6. The large percentage of recoveries within three days and seven days under such a variety of medical treatments is evidence only of the self limited character and short duration of most colds.

7. The chlorin treatment apparently was more beneficial in acute rhinitis than in any other type of acute cold.

8. The largest percentages of good results with the chlorin treatment were obtained when the patients were treated on the second or third day of the disease.

9. Ill effects that could be definitely ascribed to the chlorin treatment occurred only in persons subject to asthma.

10. The results of the treatment of whooping cough were somewhat encouraging, but not conclusive.

11. Harris, L. I.: Report on Study of Chlorin Gas as a Therapeutic Agent in Respiratory Diseases, Bull. New York Dept. Health **14**: 217 (Oct.) 1924.

12. Gilchrist, H. L.: Chlorine Gas: Its Uses One Hundred Years Ago, Its Uses Today as a Therapeutic Agent in Certain Respiratory Diseases, with Report of Nine Hundred Cases, Wisconsin M. J. **23**: 234 (Oct.) 1924.

Clinical Notes, Suggestions and New Instruments

EPIDERMOID CYST OF CERVIX UTERI

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No instance of a cyst of this nature occurring in the cervix has been found in a survey of the literature or in the standard texts of gynecology. Geller [1] reports a number of atypical epithelial growths on the cervix, but they are all either polypoid or solid tumors of possible malignant character. Wharton,[2] in 1921, reported several cases of rare tumors of the cervix, including condyloma and granuloma, but none of cystic nature. The origin of the epidermoid cyst reported here may bear an embryologic relation to Meyer's [3] "pavement epithelium nodules" found in the uterine mucosa, although he records no cystic development arising from these nodules.

The cyst here described is apparently entirely unrelated to the usual type of cyst found in this location, the nabothian or retention cyst, and affords, in my experience, a rare pathologic picture.

REPORT OF CASE

Miss G., aged 31, a schoolteacher, July 7, 1923, complained of leukorrhea of about one year's standing, and more recent pain on defecation. For the past year she had been under medical treatment for the leukorrhea, without benefit, but had had no local treatment or examination. Her family and past history were without bearing on the case.

On examination, the hymen would not permit the passage of a speculum, but digital examination showed the presence of a tumor the size of a walnut, on the right side of the cervix, extending into the right vaginal fornix, and of a cystic

1. Geller, F. C.: Atypical Epithelial Growths on Cervix Uteri, Zentralbl. f. Gynäk. **47**: 406 (March 10) 1923.

2. Wharton, L. R.: Rare Tumors of Cervix of Uterus of Inflammatory Origin, Surg., Gynec. & Obst. **33**: 145 (Aug.) 1921.

3. Meyer, R.: Pavement Epithelium Nodules in Hyperplastic Glands of Corpus Mucosa of Uterus, Arch. f. Gynäk. **115**: 394 (Nov.) 1921.

consistency. Physical examination was otherwise negative, except for the presence of hemorrhoids and an anal fissure.

At operation, August 11, under ether anesthesia, the hemorrhoids were removed, and the cervical tumor was excised. On exposure of the cervix, pressure on the tumor was followed by the appearance of a thick sebaceous exudate from the external os, resembling dental paste being squeezed from a tube. The presence of a dermoid cyst was suspected, and a complete excision made of the sac and fistulous tract opening from the cyst cavity into the cervical canal, about 1 inch (25 mm.) above the external os. This necessitated splitting the cervix and removing the portion of vaginal wall covering the thin walled sac.

Recovery was uneventful, and there has been no recurrence of the tumor or reappearance of vaginal discharge.

The tissue was sent for pathologic examination to Dr. J. J. Moore of Chicago, who found that the sections consisted of a very thick layer of squamous cell epidermis with an underlying fibrous tissue having small papillae but none of the other structures of the derma. The outermost cells of the epidermis were undergoing degeneration. No cervical glands were observed. Dr. Moore's diagnosis was epithelial cyst of the type of epidermoid cyst. He remarked that this was not a true dermoid or a true wen, in the respect that it did not originate from a sebaceous gland. He stated that the condition might have arisen from a congenital or traumatic misplacement of epithelium.

FACIAL PALSY FOLLOWING SCARLET FEVER: A REPORT OF TWO CASES

P. N. MUTSCHMANN, M.D., CALUMET, IOWA

Facial palsy, following scarlet fever with complicating suppurative otitis media and cerebral abscess, is not a rare occurrence. In the available literature, however, I have been able to find reported only one case[1] of peripheral involvement of the facial nerve due to a parotid abscess, unaccompanied by an otitis media.

During the winter of 1925, two cases of unilateral peripheral facial palsy came under my care. They are of interest in that both followed attacks of scarlet fever, with apparently only a moderate degree of glandular involvement, and both, after several months of apparently complete clinical recovery, have developed an intermittent paralysis of the seventh nerve on the right side.

CASE 1.—J. H., a boy, aged 8 years, appeared for examination because of inability to close the right eye completely, and some difficulty in mastication. In March, 1919, he had had an attack of scarlet fever of moderate severity, with some involvement of the cervical lymph nodes but no otitis. Recovery from the disease was uneventful except for the recurrence of a swelling over the right parotid gland at odd intervals. Some time later, the boy complained of inability to wink the right eye, and the parents noted the peculiar ironed-out expression of the right side of the face. The condition disappeared without treatment in the course of a week, but has returned at intervals since that time, always accompanied by a swelling over the right parotid gland. The condition again became noticeable one week before the child appeared for examination.

The general physical examination revealed nothing of importance. Local examination showed a slight generalized cervical adenopathy, and an enlargement of the right parotid gland, smooth, moderately firm, and slightly sensitive to pressure. The skin overlying the gland was freely movable and not reddened. Following palpation of the gland and milking of Stenson's duct, a yellowish-white discharge appeared in the mouth, and the size of the gland noticeably diminished. The face showed the typical appearance of a peripheral facial palsy with the ironed-out appearance of the right forehead, a partial obliteration of the nasolabial fold, inability to pucker up the lips on the right side, and inability to close the right eye. There was no apparent change in the salivary secretion, and no interference with the sense of taste or of hearing.

Blood examination revealed a white cell count of 8,600, a red cell count of 4,400,000, and a differential count of 73 per cent. polymorphonuclear leukocytes, 26 per cent. lymphocytes, and 1 per cent. eosinophils.

Slide examination of the discharge from the parotid duct showed many pus cells, much débris, and an occasional short-chained streptococcus.

The patient was requested to report for observation, but failed to do so.

CASE 2.—L. L., a girl aged 9 years, had had scarlet fever four years before I saw her, with an uneventful recovery except for a persistent cervical adenopathy, and a complaint of a recurrent salty taste accompanied by a slightly painful swelling in the region of the right parotid gland. Because of this swelling below the right ear, the patient was brought in for examination.

General physical examination showed nothing of importance. Local examination showed a generalized cervical adenopathy and an enlargement of the right parotid gland, firm and slightly tender to the touch. Following palpation of this gland, the patient complained of a salty taste, and, on examination, a thick, purulent discharge could be seen draining from the right parotid duct. Further examination showed a noticeable weakness in closing the right eye, in puckering the mouth on the right side, and in wrinkling the skin over the right forehead, a condition which the child declared had been present at different times, but which had escaped the notice of the parents. No change could be detected in the sensations of smell or of hearing, and there was no evident interference with the salivary secretions.

This patient has remained under observation and has had intervals of complete freedom from the trouble, both subjectively and objectively, without treatment.

Blood examination showed a white cell count of 9,000, a red cell count of 4,100,000, and a differential count of 79 per cent. polymorphonuclear leukocytes, 18 per cent. lymphocytes, and 3 per cent. eosinophils.

Slide examination of the discharge from the parotid duct showed no organisms.

1. Buy, J.: Parotid Adenophlegmon in a Scarlet Fever Patient, with Peripheral Facial Paralysis and Apparent Integrity of the Orbicular Muscle of the Eyelid, Paris méd. **29**: 63, 1918.

"COCK-UP" SPLINT

FRED ELLSWORTH CLOW, M.D., WOLFEBORO, N. H.

An emergency "cock-up" splint, which fulfils the requirements of this type of splint extremely well, can be made easily from a piece of wood of proper length and thickness, and a tin or papier-mâché round box. The one illustrated was improvised hurriedly, a strip of pine shingle and an empty

"Cock-up" splint.

adhesive plaster container 4 cm. in diameter and 5 cm. in depth being used. The box was fastened to the wood with narrow strips of adhesive plaster, and the whole splint padded with sheet wadding and a roller bandage. For a patient with a large hand, a deeper container should be used. In applying the apparatus, the thumb and fingers either may be immobilized or given complete freedom of movement.

A NEW SCALPEL WITH INTERCHANGEABLE BLADES

PAUL B. MAGNUSON, M.D., CHICAGO

The scalpel illustrated and described here was developed with the idea of furnishing the surgeon a blade strong enough for all purposes and all types of tissues, and sharp enough to do its work easily.

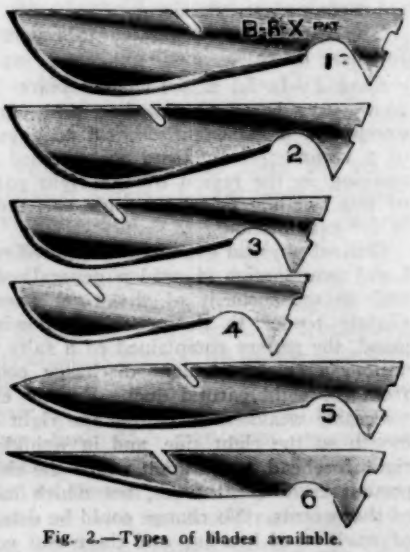


Fig. 2.—Types of blades available.

Fig. 1.—Interchangeable handle.

Fig. 3.—Application of blade to handle.

The handle (Fig. 1), which accommodates all sizes of blades, is heavy enough to give the operator a firm grip. It feels light in the hand. It has a dissecting, blunt end opposite the blade.

The six types of blades (Fig. 2) furnished with this handle are somewhat different from the detachable blades now on the market. They are made heavier and therefore in dissecting, especially in heavy scar tissue, it is possible to use the blades with a side motion, making the dissection much easier and involving no danger of breaking the blade.

Fig. 4.—Method of disengaging blade.

As will be seen in Figures 3 and 4, the blade is applied in the handle and held by a little ratchet.

It will be noted that the slit handle extends well forward over the cutting part of the knife. This gives additional strength to prevent bending or breaking. No amount of pressure on the cutting surface or sideways will dislodge the blade. The weight of the blade and the kind of steel used lend themselves to a cutting edge that will maintain its sharpness, and the knife as a whole feels like the scalpel to which the surgeon is accustomed. The knife is manufactured by Sharp & Smith, Chicago.

30 North Michigan Avenue.

New and Nonofficial Remedies

THE FOLLOWING ADDITIONAL ARTICLES HAVE BEEN ACCEPTED AS CONFORMING TO THE RULES OF THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION FOR ADMISSION TO NEW AND NONOFFICIAL REMEDIES. A COPY OF THE RULES ON WHICH THE COUNCIL BASES ITS ACTION WILL BE SENT ON APPLICATION. W. A. PUCKNER, SECRETARY.

CONCENTRATED POLLEN EXTRACTS-SWAN-MYERS.—Liquids obtained by extracting the dried pollen of plants with a liquid consisting of 67 per cent. of glycerin and 33 per cent. of a solution containing sodium chloride, 2.5 Gm., and sodium bicarbonate, 2.7 Gm., in distilled water, 1,000 Cc.

Actions and Uses.—See Allergic Protein Preparations, New and Nonofficial Remedies, 1925, p. 278.

Dosage.—See Allergic Protein Preparations, New and Nonofficial Remedies, 1925, p. 278.

Concentrated pollen extracts-Swan-Myers are marketed in 5 Cc. vials.

Manufactured by Swan-Myers Company, Indianapolis, Ind. No U. S. patent or trademark.

Annual Sage Concentrated Pollen Extract-Swan-Myers; Ash Concentrated Pollen Extract-Swan-Myers; Black Walnut Concentrated Pollen Extract-Swan-Myers; Blue Grass Concentrated Pollen Extract-Swan-Myers; Box Elder Concentrated Pollen Extract-Swan-Myers; Buckhorn Concentrated Pollen Extract-Swan-Myers; Burweed Marsh Elder Concentrated Pollen Extract-Swan-Myers; Cocklebur Concentrated Pollen Extract-Swan-Myers; Corn Concentrated Pollen Extract-Swan-Myers; Cottonwood Concentrated Pollen Extract-Swan-Myers; False Ragweed Concentrated Pollen Extract-Swan-Myers; Giant Ragweed Concentrated Pollen Extract-Swan-Myers; Goldenrod Concentrated Pollen Extract-Swan-Myers; Hemp Concentrated Pollen Extract-Swan-Myers; Hickory Concentrated Pollen Extract-Swan-Myers; Lamb's Quarters Concentrated Pollen Extract-Swan-Myers; Marsh Elder Concentrated Pollen Extract-Swan-Myers; Mugwort Concentrated Pollen Extract-Swan-Myers; Oak Concentrated Pollen Extract-Swan-Myers; Orchard Grass Concentrated Pollen Extract-Swan-Myers; Prairie Sage Concentrated Pollen Extract-Swan-Myers; Quailbrush Concentrated Pollen Extract-Swan-Myers; Red Sorrel Concentrated Pollen Extract-Swan-Myers; Redtop Concentrated Pollen Extract-Swan-Myers; Russian Thistle Concentrated Pollen Extract-Swan-Myers; Sagebrush Concentrated Pollen Extract-Swan-Myers; Short Ragweed Concentrated Pollen Extract-Swan-Myers; Slender False Ragweed Concentrated Pollen Extract-Swan-Myers; Southern Ragweed Concentrated Pollen Extract-Swan-Myers; Spiny Amaranth Concentrated Pollen Extract-Swan-Myers; Sudan Grass Concentrated Pollen Extract-Swan-Myers; Sycamore Concentrated Pollen Extract-Swan-Myers; Timothy Concentrated Pollen Extract-Swan-Myers; Western Ragweed Concentrated Pollen Extract-Swan-Myers; Western Water Hemp Concentrated Pollen Extract-Swan-Myers.

Concentrated pollen extracts-Swan-Myers are prepared by grinding dried pollen with a menstruum composed of 67 per cent. of glycerin and 33 per cent. of a solution containing sodium chloride, 2.5 Gm., and sodium bicarbonate, 2.7 Gm., in distilled water, 1,000 Cc. The extract is clarified by filtration and sterilized by passing the filtrate through Mandler filters. The finished liquid is a 3 per cent. extract of the dried pollen, each cubic centimeter representing 0.03 Gm. dried pollen (30,000 units).

ANTIRABIC VACCINE (See New and Nonofficial Remedies, 1925, p. 342).

Lederle Antitoxin Laboratories, New York.

Rabies Vaccine-Lederle (Semple Method).—An antirabic vaccine prepared according to the general method of David Semple (phenol killed). The brains of rabbits killed on the seventh or eighth day after inoculation with fixed virus rabies are ground in a ball mill for four days with physiological solution of sodium chloride containing 1 per cent. phenol to yield an 8 per cent. suspension of brain substance. The mixture is incubated at 37 C. for twenty-four hours and then diluted with an equal volume of physiological solution of sodium chloride so that the finished preparation contains 4 per cent. of brain substance. Marketed in packages of fourteen syringes each containing 2 Cc. The content of a syringe is administered daily over a period of fourteen days.

PROCEEDINGS OF THE ATLANTIC CITY SESSION

MINUTES OF THE SEVENTY-SIXTH ANNUAL SESSION OF THE AMERICAN MEDICAL ASSOCIATION, HELD AT ATLANTIC CITY, MAY 25-29, 1925

HOUSE OF DELEGATES

First Meeting—Monday Morning, May 25

The House of Delegates met in the Hotel Traymore, Atlantic City, and was called to order at 10 a. m. by the Speaker, Dr. F. C. Warnshuis, Grand Rapids, Mich.

Preliminary Report of the Committee on Credentials

The chairman of the Committee on Credentials made a preliminary report, stating that more than a quorum of delegates had qualified.

No objection being made, the report was accepted.

The Secretary stated that the registration of the delegates in attendance recorded the presence of more than a quorum.

A quorum being present, the Speaker announced that the House was constituted and ready for the transaction of business.

The next order of business was the presentation, correction and adoption of the minutes of the Seventy-Fifth Annual Session.

The Secretary stated that the minutes had been printed and circulated among the members of the House of Delegates, with the request for criticism or corrections, but none had been received.

It was moved that the reading of the minutes of the Seventy-Fifth Annual Session be dispensed with and that the minutes be approved as printed. Seconded and carried.

ADDRESSES OF EXECUTIVE OFFICERS

The Vice Speaker, Dr. Rock Sleyster, Wauwatosa, Wis., took the chair, after which the Speaker delivered his address:

Address of the Speaker, Dr. F. C. Warnshuis

Members of the House of Delegates:

In being privileged to address you at the commencement of your annual deliberations, your Speaker senses deeply the trust that you have expressed in permitting him once more to preside over this legislative body. To acquit myself of that trust, to facilitate and enhance your labors, to afford each and every delegate the privileges to which he is entitled so that he may ably represent his constituents and to cause this session to record enactments that will contribute commendably to the interests and future of our great Association will be my sole motive and endeavor. To that end do I bespeak your cooperation.

REFERENCE COMMITTEES

Reference committee appointments have been selected from hold-over delegates. Announcement of these appointments was made in THE JOURNAL. It was purposed to afford committee members the opportunity of familiarizing themselves with submitted reports and so expedite their labors. The recommendation is tendered that committee chairmen call early meetings of their committee and give ample notice of the time and place of their meeting, so that delegates as well as interested Fellows may appear at committee hearings.

There are several important problems that await your consideration, for the formulation of guiding policies and instructions. They include public health education, medical education, legislation and organizational activity. Their importance cannot be overemphasized.

As these subjects are introduced through council, bureau, trustees', officers' and committee reports, or by resolution, they will be referred to the proper reference committees. Need for definite, constructive action presses. In order that just and full opportunity be afforded for their consideration, it is recommended that, if reference committees feel that certain reports or resolutions merit further consideration after committee hearings have been held, the committee should make early request for the reception of its report by this House of Delegates convening as a Committee of the Whole.

ASSOCIATION SECRETARY

Our By-Laws provide that the Secretary of this Association shall be elected annually by the House of Delegates. Our Board of Trustees has wisely drafted our Secretary and elected him General Manager of our Association. This action I feel certain has the approval of every delegate, for it has placed in that high office a most capable and efficient official who possesses our every confidence and esteem.

To fill the office of Secretary is a pressing and difficult problem. Available men are loath to relinquish their work to accept an office that calls for an annual reelection. Our Secretary is and must be in close contact with the Board of Trustees. It would therefore seem to be wise to delegate the selection and election of a Secretary to the Board of Trustees. To establish that procedure, it is recommended that the By-Laws be amended at this session in order that the Board of Trustees may be so empowered to act.

INTRODUCTION OF RESOLUTIONS

As time passes, new events are encountered and with them there are brought to us new problems requiring solution. Our only means for recording a policy or uttering a pronouncement that represents our Association's position is by the adoption of a resolution. It has always seemed that, in dealing with momentous problems and far-reaching questions of policy, our final attitude should be attained and enunciated only after mature and careful consideration. Under our present plan, delegates and Fellows frequently first learn of a resolution at the time it is introduced. Scant opportunity is afforded for reflection, investigation and the formulating of individual judgment. Would it not be well to adopt a rule that resolutions bearing on or dealing with matters of policy and opinions must be submitted thirty days before our annual session and published in the *Bulletin* that is to be mailed to every delegate? Such a rule would permit each delegate to familiarize himself with the provisions contained in resolutions and would beget more considerate action. Such a rule or a similar one is worthy of your consideration. It must not be permitted, however, to cause such a rule to obstruct or prevent the introduction of resolutions on matters that arise in the annual meetings of constituent state organizations that convene within the thirty day period. The suggestion is tendered for your consideration.

DELEGATES' RESPONSIBILITY

I would be remiss did I fail to call to your attention the individual responsibility that is yours as a delegate, representing the members of your state organization.

One year ago, President Wilbur said:

> Medicine in the last thirty years has gathered together a fund of information which, if it could be directly applied to the benefit of every individual, would prolong life and happiness and change the whole current of human thought and life. The fund of information is available. We stand between that information and the public. It is our problem to provide for its distribution. If we make these provisions wisely, if we meet the situation, then we shall maintain the mastery; if we fail, general education has reached such a level that others will begin to demand that there will be a distribution of this information available to the human race, and we shall lose our position of mastery.

Such, then, is your responsibility. It is the duty that you owe not only to your fellow-members but to the people at large and to the nation. May you seek to cause your transactions to reflect that you have not been unmindful of all that is involved in your activity as a delegate.

Your work is not limited to the four or five days of our annual meeting. It should continue through the interim of our sessions. It is incumbent on each delegate not only to convey to his state association that which has been enacted at these

annual meetings, but also to impart at all county or district meetings that he may attend that which the American Medical Association is accomplishing and seeking for the welfare of physicians as well as of the people. There is need for such educational activity. It is a duty that should be discharged by every delegate.

In the final analysis, the members of this House of Delegates dictate the program of our federacy. This federacy, which makes possible our American Medical Association, represents the medical profession of America. We stand before the people of the nation, representing a science that is concerned with the welfare of all mankind. A tremendous power for good is under our control. A tremendous responsibility is therein entailed. The consciousness of that responsibility cannot be lightly assumed.

MEDICAL PUBLICITY

Publicity is resorted to by every cult and by the exploiters of fads and fallacies. The purpose of their publicity is to further their individual and selfish ends. In so doing they profit and obtain financial revenue solely for themselves. They do not contribute to or benefit the welfare of the public. On the contrary, the public suffers, pays a penalty, as a rule, and is deprived of all benefit or profit.

Scientific medicine, as represented by this national Association and its constituent state and county organizations, has no secrets that it withholds. As far as we are concerned, that which benefits us benefits the public. Though we may profit, the people, the public, all humanity profits to a greater degree and receives returns that are of value in a full measure. This is in distinct reverse of cult or pseudoscientific advertising policies.

These facts being so, does it not then become our duty and are we not morally obligated to give careful thought to a definite, progressive policy of publicity for the economic and social reasons that affect us as physicians, and what is more important, the social and economic conditions that involve all human kind? In contradistinction to the cultist, the faddist and the quack, let it become widely known that scientific medicine is founded on sound, proved tenets that have withstood the tests and are accepted by reason of their intrinsic worth; that it has no secrets, mystic powers or functions. Let it be known that as we, as physicians, advance, the people likewise benefit and profit; that as the social status of the physician is enhanced and elevated, better service ensues and from that higher, more efficient type of service the people in every station of life obtain benefits that tend toward giving to them greater physical, social, economic happiness, prosperity and individual well being.

I am deeply impressed with the need of undertaking a more active plan of medical publicity through our Bureau of Health and Public Instruction, and that we extend the efforts of that bureau. In advising increased measures of publicity and public education, I commend to you the recommendation that was made in 1783 by a London physician, and which I quote from the writings of one of our delegates, as follows:

> No laws will ever be able to prevent quackery, while people believe that the quack is an honest man, as well qualified as the physician. A very small degree of medical knowledge, however, would be sufficient to break the spell, and nothing else can undeceive them. It is the ignorance and the credulity of the multitude with regard to medicine which renders them such an easy prey to every one who has the hardiness to attack them on this quarter. Nor can the evil be remedied by any other means but making them wiser. The most effectual way to destroy quackery in any art or science is to diffuse the knowledge of it among mankind.

Is the time not at hand that we accept this obligation, follow this advice uttered a century and a half ago, and set forth to diffuse this knowledge among the people by means of more extended efforts than we have heretofore manifested? Your Speaker invites your giving consideration to this question of extended medical publicity and public enlightenment.

DEATHS

Since our last annual session, death has again invaded our ranks. Dr. W. T. Williamson, chairman of our Board of Trustees and a former delegate, "lay down to silent dreams," March 2, 1925. The allotted three score and ten years were his. Endeared to all who knew him, magnanimous in spirit and deed, helpful to his fellow men, giving freely of himself for all that scientific medicine represents, and at all times seeking to build bigger and better, he is now enshrined in our memory. We record our respect and appreciation. May that memory inspire and direct us the better to do that which lies before us in the years that are to be ours.

Another ex-President, delegate, fellow member and esteemed co-worker, Dr. Eugene Solomon Talbot of Chicago, responded to the last call, Dec. 20, 1924, at the age of 77. Dr. Talbot was largely instrumental in founding the Section on Stomatology, and served as its secretary from 1901 to 1918, and as chairman from 1918 to 1919. He was also a delegate in the 1921, 1922 and 1923 sessions. At Portland, in 1905, and again in Atlantic City in 1919, he was elected third vice president of our Association. For his fundamental scientific studies, for his leadership and ideals, both by precept and by example, Dr. Talbot's name will have enduring memory.

Dr. John Newell Hurty of Indianapolis, March 27, 1925, at the age of 73, answered the final summons of man. His genial personality and his enlightened leadership earned for him the support and love of his fellow men. Dr. Hurty served as a delegate in this House for four years, and all men profited by that service. Prominent in the fore ranks of the profession of his state, seeking the good to benefit all people, noble in purpose and deed, Dr. Hurty ennobled all medical men.

Quietly thus do the years record the passing of our esteemed associates. Each in his own sphere and by methods characterizing his individuality contributed to our prestige and progress as an association. Our spoken words are but little recompense: they can but partly assuage the sorrows of the immediate family—still they serve to write in our records, for posterity to read, that which these departed Fellows achieved.

CONCLUSIONS

The several submitted reports reveal our present activities and progress, and set forth facts and problems that call for appropriate action. There is need for tolerance and thoughtful deliberation. Your Speaker has no other recommendations to proffer. During the year I have sought faithfully to discharge the duties that are delegated to this office, and I want you all to know that I am sincerely grateful for the courtesy, tolerance and confidence that you manifest toward me. I stand before you as your humble servant, seeking naught but to do that which in spirit and deed conserves the confidence of the people in medical science and at the same time inspire our Fellows to reflect the nobler aims of their profession. Again I thank you.

Address of President William Allen Pusey

The Speaker introduced the President, Dr. William Allen Pusey, Chicago, who delivered the following address, which was referred to the Reference Committee on Reports of Officers:

Mr. Speaker, Members of the House of Delegates, and Ladies and Gentlemen:

I wish to first express my feeling of loss in the death of Dr. Williamson, Chairman of the Board of Trustees. There was a peculiarly attractive quality about his personality which quickly endeared him to those who came in intimate contact with him. He was a devoted, far-sighted trustee, with wisdom, poise and tact, and in his death the Association has lost one of its most useful servants.

It seems appropriate on this occasion, which is really the President's valedictory, that I should give you a brief account of the high trust with which you have honored me; and at the same time give you, for what they are worth, some of the impressions that have come to me in the experience.

The first oustanding impression that I have gotten in this experience is the wisdom of electing the president one year before his term of office begins and having him an active officer of the Association for the year that he is president-elect. This seems to me a useful plan. Every president must feel the responsibility, as well as the honor, of the position and the obligation to live up to these as far as possible. The year as president-elect, with the active participation in the Association's affairs which it provides, gives the president a valuable opportunity of familiarizing himself with the duties of his position and for preparing to meet them.

One of the pleasantest but most exacting privileges of the president is to respond, as far as he can, to the invitations he receives to attend meetings of constituent societies. No one can accept more than a small part of such invitations, but I have tried to meet these requests as far as possible, and I have been able to attend many of these meetings in widely separated parts of the country. I can bring you good reports from the state and county societies that I have attended. They are performing their functions for the most part zealously and intelligently. Their personnel is, as I have met the members, of the same sort wherever one goes. No better groups of men can be collected.

The visiting of state societies in particular is, I believe, a useful as well as a pleasant duty of the President. In no other way that I know can one in a short time get so fully in touch with the profession of the country, with the conditions of medical men and medical practice, and with professional problems. I know nothing that adds more to the stimulation that one genuinely feels from the experience of this office than the impressions that accumulate on him as a result of attending these meetings. It is not for me to say whether these visits are of use to the state societies, but I think I can say that they should be very useful to the Association itself.

Most of us are actually very ignorant of the administrative workings of the Association and of the efforts it is making to meet the problems of medicine as a whole and of medical men individually. It is desirable that that information be carried with us over the country as far as possible, and this can be done in these visits of officers. There is another message which I believe it is useful to carry to the state societies, and that is the statement that the Association realizes the vital importance to the Association of the prosperity and enlightenment of the constituent societies; that only as these are prosperous and enlightened can the Association as a whole be. I think that the constituent societies as a general thing know that this is true, but often fail to feel that we realize it.

There is another message which I believe we should carry on these visits to the state societies, and that is that we can best help them as they help themselves. There is a strong tendency among some of us, as there is in citizens in general of the United States, to look to the central organization to do those things that the state and the local organizations should do themselves. This sort of centralization is dangerous; it is weakening; it is likely to be ineffective in action. The Association's functions should be those that deal with questions that are of national extent. We should be in a position, as we are, to give state and local societies information and advice when it is asked for in matters and in contemplated policies that concern the county and state societies. But in these things the constituent societies should act finally for themselves.

The officers of the Association by informing themselves of its affairs and by carrying its messages to the constituent societies perform a very valuable service, not only in diffusing knowledge of the Association, but in improving the understanding between the central organization and those who make the central organization possible.

Another privilege of the president that is equally enlightening is attendance on the meetings of the Board of Trustees and of the many council and committee meetings, in which it is one of his functions to be a participant. Through attendance on many of these meetings, extending over two years, I have gotten a much more vivid impression than I had before of the importance of the functions of these various bodies, of the far reaching influence of many of their actions and of the complexities and difficulties of their problems. It has led me to realize that in many matters our wisest policy is one of careful conservatism; that some of our problems are problems which for the time being we can only study carefully but not hope suddenly to solve.

With respect to the Board of Trustees, my experience has brought home to me the very heavy responsibilities and importance of its functions. One incompetent or reckless board might irreparably damage, if not wreck, the Association.

But the point of all others which has been impressed on me in my two years is the preponderant importance to the Association of the actions of the House of Delegates. The responsibilities of the Association are distributed as follows:

The Board of Trustees, the creature of the House of Delegates, is the responsible authority for the conduct of the affairs of the Association as a business institution. It is the agent of the House of Delegates, which, through frequent meetings and constant contact with the executive departments of the Association, carries on the Association's affairs between the meetings of the House of Delegates. The House of Delegates meets its responsibilities in two ways: one, by selecting the officers who administer the affairs of the Association; the other, by establishing, through its actions, certain of the policies of the Association.

There can be no question of the critical importance of the responsibilities of the House of Delegates. The wise discharge of them makes the Association. I have no reservations in my opinion that the House of Delegates has always lived up well to its responsibilities. But there are certain weaknesses, if not dangers, inherent in the way it must do its business, that I think are worthy of careful consideration. These pertain essentially to the short time in which the business of the House must be transacted. The House meets for only three days, when all its actions for a year must be completed. It is impossible that policies and programs can be given mature consideration in that time. In view of this situation, it seems to me worth while to consider whether some arrangement could not be devised by which more time in fact for consideration of measures on which the House must act could be given to its members. I do not believe it is practicable to undertake to have more frequent meetings of the House or to lengthen the time of its meetings. Even if it were practicable to add one or two additional days to the meeting of the House, this would not cure the difficulty. It would seem, however, that some plan might be devised whereby important questions to go before the House might get to the attention of delegates long enough before the meeting for them to have time to acquaint themselves with and consider these measures. To this end, I believe, it would be a wise provision that, subject to certain exceptions, all new business that is to go before the House of Delegates, all reports of officers and addresses of officers carrying recommendations or suggestion of policy, should be sent to delegates a specified time in advance of the meeting, or should lay over, wherever practicable, until the next meeting of the Association.

It would be particularly desirable for members of the reference committees to have for a considerable time in advance of the meeting the opportunity for consideration of these matters which are to be referred to them. The obstacle to any such procedure now is that the House of Delegates and the reference committees do not exist until a few days before the time of the meeting. This matter is so important in its bearings on the actions of the House of Delegates that to my mind it warrants considering whether it would not be desirable to provide that delegates to the House for any year should be elected a specified period in advance of the time of the meeting—a period long enough to enable the delegates, and particularly the reference committees, to become familiar, before the meeting, with subjects coming before them.

My own opinion is that it would be desirable to make the provision if possible that delegates should be elected in the preceding calendar year. This would not only give them an opportunity to familiarize themselves with business coming before the House, but would give new delegates an opportunity to familiarize themselves with their duties as well and increase their sense of responsibility.

If some provision of this sort were made, I believe it would also be wise to make a provision that the Speaker of the House should appoint the reference committees at least two months before the time of meeting, with a view to having them take up individually before the time of meeting the subjects which are to come before their committees for consideration.

I venture to believe that these details of procedure are worthy of consideration, because of the very great importance of efficiency and wisdom in the conduct of the affars of the House and because they would tend more to make the House the determiner in fact of its policies. As it is now, the House of Delegates elects the responsible officers of the Association, and promulgates certain policies. But, as a matter of fact, many of the most important policies of the Association are actually entirely determined by the various councils of the

Association. I think it is desirable that a council should suggest policies, but I think it is not desirable that it should in effect determine and carry out for the Association policies of the most far reaching importance without actual careful check and control by the House of Delegates.

And in this respect now, I think it must be said that the House of Delegates does not have effective check and control on many important policies. Not only does it not have time to consider them, or for full discussion in the meetings of the House, but there is one particular in which the plan of organization seems to me to weaken in essential respect the House of Delegates' control on the policies of the councils. That is in the provision that in respect to some councils the members of the councils are ex officio members of the reference committees. The working of this provision amounts to this:

A council makes a report to the House of Delegates. This report is referred to a reference committee. The only reason for the existence of this reference committee is that the report submitted should have independent and detached review and consideration. But, as it now stands, this report is referred to a committee which is composed 50 per cent. of the Council that has made the report. That is, in effect, the Council reviews its own report and may determine the reference report which shall be made on its own original report. And, in view of the fact that the officers of the councils might, through their familiarity with the problems, very likely be called on to write the reference committee's report, the situation is one in which it might very easily occur that the reference committee's report on a report may be not only determined but actually written by those whose report it is supposed is being reviewed. When the reference report comes back to the House of Delegates, the House, because of physical limitations in time and otherwise, is not in a position to give it critical consideration. The final result is that very far-reaching policies might be promulgated as policies of the Association, determined by the House, while as a fact they are policies determined by councils without any mature consideration by the House.

It seems to me that this is not an arrangement with proper checks and controls and with proper opportunity for review, as must be intended by the provision of reference committees for consideration of reports. If the House of Delegates wishes actually to determine its policies, it seems to me it might very well consider such revision of its rules as would limit the reference committees to members of the House. This would not, of course, preclude the appearance of any one before the reference committee, for hearings of reference committees should be open.

The functions of the councils are so important as respects public policy that it also seems to me that the question might very well be considered whether some of the councils of five should not be increased in number to nine. I can also see the danger in too close adherence to the precedent of reappointing members of the councils. There should be a certain amount of adherence to this course in order to insure a continuity of knowledge of the policies and procedures, but a certain amount of infusion of new blood is always desirable in any organization.

Let me say, I know it might very well be said in reply to these suggestions that the House of Delegates has been succeeding in attending to its business efficiently under its present working arrangements. I sincerely agree with this proposition. I do, however, believe that there are dangers of centralization inherent in the rules and procedures of the House now that are worthy of attention, even if they have not developed in the past. For these reasons, not, I hope, through any tendency to captious criticism, I respectfully bring these details to your attention.

The presidency of the Association has been a stimulating experience. It adds to one's confidence in the American Medical Association and to his respect for the American medical profession. It has in addition to its honors sometimes its laborious side, perhaps, at times, a militant aspect, but I hardly think any man could go through the experience without being better for it.

The address of the President-Elect, Dr. William D. Haggard, will be found in the Addendum.

Reports of Officers

REPORT OF SECRETARY

Dr. Olin West, Secretary, presented the following report, which was referred to the Reference Committee on Reports of Officers:

To the Members of the House of Delegates of the American Medical Association:

I have the honor of submitting the following report for the year 1924-1925:

Membership

The membership of the Association as enrolled, April 1, 1925, was 90,646, which is 590 more than the membership recorded at a similar time in 1924.

Fellowship

There were 56,121 names on the Fellowship roster, April 1, 1925. This represents a gain of 2,058 over the number of Fellows reported to this House last year. While 5,104 new names were placed on the roster, 3,046, including the names of Commissioned Officers in government services, were removed. These removals were due to: deaths, 608; resignations, 720; nonpayment of dues, 369; not eligible, 713; not found, 24; commissioned officers not on active duty, 612.

The increase of more than two thousand in the Fellows of the Association is very gratifying, because it establishes their number at a much higher figure than ever before recorded, and because it indicates a growing tendency on the part of the members generally to contribute directly to the financial support of the Association and to participate more actively in all its work.

Many of the secretaries of constituent state associations, some of their journals and a number of county society bulletins have cooperated splendidly in efforts to acquaint the whole membership of the Association with the facts about Fellowship. This has had good effect and has already produced a number of applications. It is expected that greater results will finally accrue from the work that these state and county secretaries and editors have done in this matter.

The number of Fellows in each state is shown in an accompanying table.

Constituent Associations

The largest of the constituent state associations have made splendid progress in perfecting and in carrying out constructive programs during the past year. This may also be truly said of several whose membership is more limited and even of some with a very small membership.

Very few of the state organizations have "marked time," and there are only one or two now from which satisfactory reports cannot easily be secured. It is undoubtedly true, generally speaking, that the constituent associations as such are stronger and better than ever before.

This is in large manner due to better organization and increased and concerted activity in the standing and special committees of the state associations, under the guidance of their duly chosen officers. More of the state associations have developed or are developing definite programs of work than ever before; more of their members have been called into action in devising and in carrying out these programs; more and more the spirit of team work is being fostered and developed; and, finally, more than ever before the progressive state association is striving to bring home to the individual member his own responsibilities and to secure to him direct benefits growing out of his membership and his participation in the work of the organization.

While there are problems that are common to all state associations, there are also problems peculiar to each. For that reason, the programs of the several states vary materially. One association deals intensively with one or two specific questions that press for solution which may not be immediately urgent in another state. Thus, one devotes its principal efforts, aside from its scientific work, to matters of legislation; another seeks to develop a satisfactorily effective plan for the instruction of the public; still another devotes its energies to the solution of some other problem

which is thought to be of greatest importance. So it is that experience is being gained in a number of states which will enable each association to help the other; and that they will help each other is shown by the fine spirit of cooperation that has already been demonstrated in many ways.

Four additional state associations have secured full-time executive secretaries during the past year. These are Indiana, Michigan, Minnesota and West Virginia. The employment of such officers is being considered in other states.

Organization of Constituent Associations

State	Number Counties in State	Number Component Societies in State Assn.	Number Counties in State Not Organized 1924	Number Counties in State Not Organized 1925	Number Physicians in State (9th Ed. Direc. tory)	Number Members of State Association 1924	Number Members of State Association 1925	Number A. M. A. Fellows in State
Alabama	67	67	..	..	2,284	1,602	1,595	399
Arizona	14	11	3	3	378	225	222	153
Arkansas	75	66	10	10	2,212	1,197	1,249	479
California	58	40	16	16	8,363	3,929	3,436	3,012
Colorado	63	25	25	25	1,837	1,090	1,083	704
Connecticut	8	8	..	..	1,884	1,160	1,201	750
Delaware	3	3	..	..	256	147	155	84
Dist. Columbia	...	...	..	..	1,813	566	537	374
Florida	63	28	24	33	1,456	514	673	334
Georgia	161	93	54	57	3,122	1,716	1,671	841
Idaho	44	10	17	17	416	260	263	170
Illinois	102	95	4	4	10,743	6,658	7,107	5,316
Indiana	92	84	6	6	4,251	2,735	2,716	1,520
Iowa	99	97	..	..	3,378	2,459	2,374	1,540
Kansas	105	60	31	42	2,364	1,640	1,594	926
Kentucky	120	110	10	10	3,041	1,969	1,778	775
Louisiana	64	37	24	21	1,991	1,169	1,255	665
Maine	16	15	1	1	1,037	767	753	378
Maryland	23	21	..	..	2,313	1,231	1,264	795
Massachusetts	14	18	..	..	6,187	4,078	4,128	2,757
Michigan	83	57	7	7	4,837	3,181	3,051	1,816
Minnesota	87	38	6	8	2,823	2,042	2,087	1,315
Mississippi	82	37	4	9	1,702	1,024	947	318
Missouri	115	101	6	7	5,806	3,292	3,335	2,000
Montana	55	16	35	39	625	303	259	109
Nebraska	93	56	34	34	1,860	1,239	1,220	743
Nevada	17	3	14	14	129	115	100	78
New Hampshire	10	10	..	..	601	499	504	268
New Jersey	21	21	..	..	3,567	2,092	2,118	1,545
New Mexico	31	13	15	15	365	201	263	145
New York	62	60	1	1	17,671	10,087	10,396	6,480
North Carolina	100	71	20	20	2,281	1,656	1,612	606
North Dakota	53	14	2	2	485	395	380	288
Ohio	88	85	3	3	8,113	4,750	5,206	2,850
Oklahoma	77	69	9	9	2,524	1,539	1,686	742
Oregon	36	17	1	2	1,176	589	482	361
Pennsylvania	67	63	4	4	11,140	7,433	7,474	4,659
Rhode Island	5	6	..	..	771	399	411	297
South Carolina	46	41	5	5	1,317	916	957	396
South Dakota	69	11	1	2	604	356	352	239
Tennessee	95	67	27	25	3,128	1,711	1,616	709
Texas	254	135	66	73	6,063	3,650	3,758	1,800
Utah	29	6	23	22	505	256	230	246
Vermont	14	10	3	3	537	389	365	190
Virginia	100	52	43	43	2,534	1,843	1,845	754
Washington	39	19	20	20	1,781	1,122	1,166	673
West Virginia	55	28	14	14	1,753	1,142	1,174	586
Wisconsin	71	53	1	2	2,826	1,914	1,846	1,322
Wyoming	23	7	12	13	255	163	135	102
Alaska	...	...	..	..	56	20	20	10
Hawaii	5	...	..	..	225	92	104	49
Porto Rico (districts)	7	...	..	..	321	125	158	37
Canal Zone	...	...	..	..	127	102	90	27
Philippine Islands (provinces)	56	...	..	..	905	151	151	47
Foreign	...	...	..	..	.....	.....	.....	58
Totals	3,136	2,064	597	641	148,644	90,056	90,646	53,809
Commissioned Officers, Honorary and Affiliate Fellows								2,222
								56,121

Several constituent associations are now conducting extension courses for the benefit of members of their component societies. The Michigan State Medical Society has recently instituted such courses, and they have apparently been enthusiastically received. The plans under which clinical instruction is carried to the members at a central place, easily reached by the physicians of one or more counties, vary to some extent in the different states. In some instances the work is done through the cooperation of the state association and the state university; in others, wholly as the enterprise of the association. In one state, at least, the state university is the leading factor. However the movement may be organized and conducted, there can be no doubt concerning the value of such efforts to promote the scientific efficiency of those members who cannot go at regular intervals to the centers where the more elaborate courses of graduate instruction are offered. The clinics and lectures of the state association's "home course," properly conducted, will be stimulating to those who, by a little extra effort and sacrifice, can avail themselves of the benefits of more intensive and extensive courses offered by graduate schools and hospitals; they will undoubtedly contribute to some extent to greater professional efficiency on the part of those who cannot get away from their homes for attendance at graduate schools.

There are twenty-two constituent associations each of which has less than 1,000 members. Of these, there are seventeen having less than 500 members each, and nine of these have each less than 200. All these labor under the disadvantages that are imposed by their small memberships, but they nevertheless carry on with courage and acquit themselves with credit.

The Medical Society of Porto Rico has reorganized with seven component societies. These supplant the two district societies which were the units of organization in Porto Rico. This is in accordance with the plan whereby the county is made the basic unit of organization. There are now only one or two state associations that do not fully conform to this plan.

Component County Societies

It seems probable that more county societies have been persistently active during the last year than for a number of years. It is certain that many have broadened their programs and have extended their usefulness, with relation both to their members and to the public. Some inactive societies have been revived. However, there are yet too many that are dormant. These have no programs, no purpose, no value. They serve only to give those whose names are enrolled as members entrée to the state associations and the American Medical Association, and to make them eligible for remunerative connections with corporations. The members of these societies that exist only "on paper" thus enjoy privileges which they do not earn.

The problem of the inactive county society is one not always easy of solution. There are geographic and topographic factors; and there are personal and physical factors in the problem. Occasionally, it may be, the officers of the state association are not as active as they might well be in trying to "stimulate the zeal" of the members of a dormant county organization. In some instances it is probable that charters have been issued to county societies for which there could be no hope for the development of efficiency as medical organizations.

In some states, effort is being made to attach the weaker societies to those that are already strong, or to combine two or more weak societies in the hope that one strong one may be developed. In other states the district society is being fostered and strengthened as an aid to the county society. Both of these plans are altogether worthy of thorough trial in any state in which inactive county societies are to be found; but all possible effort should be made to keep up efficient organization in every county having a sufficient number of eligible physicians to make an active society possible.

A few county societies have developed their own plans for intensive clinical instruction. In some instances the diagnostic clinic is made the feature of these programs; in others, special addresses are delivered at regular intervals in accordance with a well prepared schedule. While it is not every county society that can successfully carry out work of this nature without aid from outside its own membership, many can do so to splendid advantage. Many others can easily secure aid that may be required.

A few county societies, also, have devoted especial attention to the subject of periodic medical examinations and have succeeded in arousing the interest of their members in this important subject.

Annual Conference of Secretaries of Constituent State Associations

The annual conference of secretaries of constituent state associations was held in Chicago in November, 1924. Thirty-seven secretaries were in attendance. The editors of thirteen state journals were also present. There was, possibly, more

of frank and helpful criticism, more of constructive suggestion, more of specific proposal for the adoption of definite programs of work than at any previous conference. No finer spirit of cooperation can be found in any group than that which is in evidence at these annual conferences. What the lessons of experience have taught in one state is freely passed on for the benefit of all the states; what is proposed for the future in any state is submitted to critical analysis, and the benefits of open discussion and friendly suggestion are secured.

The American Medical Association Bulletin

The Bulletin is now going to the more than 56,000 Fellows of the Association. It is apparently widely read, if the large number of letters received commenting on its content mean anything in that connection. Practically all these letters have been commendatory, indicating, perhaps, that the Bulletin is satisfactory in quality to its readers. Its editors are not at all satisfied with it, for the reason that its real purpose is not being fulfilled. The members of this House of Delegates, the officers of state and county societies, and the individual Fellows of the Association who could helpfully discuss the problems of medical organization and the subjects of every day interest to physicians are not utilizing the Bulletin in the way it was intended that it should be used by them.

Reapportionment of Delegates

Change in Constitution and By-Laws

The Committee on Reapportionment of Delegates at the Chicago Session recommended that the Constitution and By-Laws should be so amended as to provide for a possible increase in the number of Delegates to be elected by constituent state medical associations; and that the regular triennial apportionment in 1924 should be made on the basis of one delegate for each 950 members or fraction thereof. These recommendations, approved by the House, were based on the following facts: When the limit of membership of the House of Delegates was fixed at 150, constituent associations had less than 50,000 members, whereas in 1924 there were more than 90,000. Each scientific section and each of the three government medical services has one delegate. Not more than 132 delegates could be elected to represent the general membership of the Association. The number 950 was selected as the basis for reapportionment last year because a smaller number would have produced more delegates than the limit set by the constitution, while a larger even number would have unduly cut down the representation of many constituent associations.

The amendments proposed by the Committee on Reapportionment, to be acted on at this session, are:

Amend Section 3, Article 5, of the Constitution by substituting 175 for "150" in the second line, so that the first sentence in this section shall read:

> The total voting membership of the House of Delegates shall not exceed 175.

Amend Section 3, Chapter 1, of the By-Laws by substituting 1925 for "1903" in the second line, so that the first sentence of this section shall read:

> At the annual session of 1925, and every third year thereafter, the House of Delegates shall appoint a committee of five on reapportionment, of which the Speaker and the Secretary shall be members.

The adoption of these proposed amendments will necessitate a new apportionment of delegates at this session. It is suggested that action should be taken by the House at the earliest possible time, so that if the proposed amendments are adopted a Committee on Reapportionment can be appointed and have time for the preparation of its report to be submitted to this House.

Other Proposed Amendments

A proposed amendment to the Constitution, submitted at the Chicago Session, seeks to have the President-Elect made one of the general officers of the Association, as follows:

Amend Section 1, Article 6, of the Constitution by inserting after the word "President" the words President-Elect.

The following proposed amendment to the By-Laws was submitted on the last day of the Chicago Session:

Amend Section 1, Chapter IV, of the By-Laws by inserting after the first sentence in this section the following:

> At some time between the first and fourth day of the Annual Session of the House of Delegates, the chairman and the secretaries of the various sections of the Scientific Assembly and the members of the Council on Scientific Assembly shall meet at the call of the chairman of the Council on Scientific Assembly and shall prepare and present to the House of Delegates, at their meeting on the fourth day of the annual session, three nominees for the office of President-Elect and two nominees for the office of Vice President, and the nominees so presented shall be the only ones eligible for election.

Official Visits to State and County Societies

Whenever possible, in response to invitations, officers of the Association have attended meetings of state associations and county societies. The President, President-Elect, members of the Board of Trustees, the speaker of the House of Delegates, the Editor of The Journal, directors of Bureaus, secretaries of Councils, and the Secretary of the Association have all responded to official invitations of the kind indicated and have endeavored to acquaint the members of the societies visited with some of the details of the numerous activities of the Association and to ascertain how its service to its constituent and component units can be extended and improved. As a result of these official visits information has been brought back to the Association's headquarters which has, in all instances, been acted upon in a manner that has been intended to serve to the advantage of the general membership.

Delegates from the British Medical Association and from the Canadian Medical Association

The Association will be honored at this session by the presence of official delegates representing the British Medical Association.

The Canadian Medical Association will again be officially represented by its Secretary, Dr. T. C. Routley, whose appearance in similar capacity before the House of Delegates at San Francisco will be most pleasantly recalled.

Acknowledgment

The Secretary has again to acknowledge the kindly consideration and help he has received from the entire official personnel of the Association, including the members of this House. The officers, and especially the secretaries of state associations, have placed him under deep obligation by reason of their prompt, courteous and helpful response to his official communications. The cooperation received from these sources has been finer in the past year than ever before, which is only to say that it has been well nigh perfect.

From the officers of county societies, from the editors of state journals and county bulletins, and from many individuals turned to for information and assistance, kindly and truly helpful response has been made to nearly all appeals.

Olin West, Secretary.

REPORT OF THE BOARD OF TRUSTEES

Dr. Thomas McDavitt, St. Paul, Vice Chairman, presented the following report, which was referred to the Reference Committee on Reports of Officers:

To the Members of the House of Delegates of the American Medical Association:

Death of Dr. W. T. Williamson

Dr. Walter T. Williamson, Chairman of the Board of Trustees, died at his home in Portland, Ore., March 2, 1925. Dr. Williamson, because of his courteous bearing and his kindly consideration for his fellows, and because of his devotion to duty as an officer of the Association, won for himself a high place in the esteem and affection of all with whom he was officially associated. The Board of Trustees will, at a later time, present formal resolutions on the death of Dr. Williamson.

Retirement of Dr. Simmons

Dr. George H. Simmons, having completed more than twenty-five years of honorable and distinguished service as Editor and

General Manager of the Association, retired from active duty, Sept. 22, 1924, after presenting a characteristically thorough accounting of his stewardship. Dr. Simmons, in accordance with action taken by the House of Delegates, is now Editor and General Manager Emeritus.

On Nov. 22, 1924, after election by the Board of Trustees, Dr. Olin West assumed the duties of General Manager. Dr. Morris Fishbein, by action of the Board, became Editor, and Mr. Will C. Braun, Business Manager.

THE JOURNAL

The general policies of THE JOURNAL have been maintained as heretofore. No major changes with respect to the general make-up and the character of the contents of THE JOURNAL have been put into effect. Effort has been made, however, to have more editorials discussing current events, subjects pertaining to medical economics, and other matters of immediate interest to the general profession.

There has been continued improvement in the news columns of THE JOURNAL.

The department devoted to the proceedings of medical societies is being further developed.

The editorial plans for THE JOURNAL contemplate sustaining it as the periodical essential to the progress of the general practitioner.

SUBSCRIPTION DEPARTMENT

On Jan. 1, 1925, the mailing list of THE JOURNAL contained the names of 85,536 subscribers, which number represents an increase of 4,578 over the preceding year, and marks the highest point attained in subscriptions in the history of the publication.

On Jan. 1, 1924, the subscription price of THE JOURNAL was reduced from $6 to $5. This reduction may have been responsible to some extent for the increase in circulation, but it is not believed to have been a very material factor. The reduction of the subscription price of THE JOURNAL resulted, of course, in a very material decrease in the annual income of the Association.

The Subscription and Membership Departments have pursued the same methods that have been found advantageous in the past in maintaining the circulation of THE JOURNAL. Special effort has been devoted to holding subscribers, as well as to obtaining new subscription orders. Due diligence has been used in making collections on current and past accounts.

Subscription is maintained through direct appeal to individuals by sending out form letters, 101,783 of which were mailed during the year; by distributing sample copies, with or without such letters; through the efforts of agents, some of whom are students in medical schools; by the judicious distribution of sample copies of special numbers of THE JOURNAL among hospitals, other institutions and groups; and, finally, to a limited extent, through the offer of a premium of substantial value to prospective subscribers. One man was in the field in Georgia, and later in New Jersey, soliciting subscriptions to the publications of the Association and inviting eligible men to become members of the medical associations of these states, working, of course, under the direction of the proper officers of the state and county medical societies. As a result of his work, 232 applications for membership (ninety-six in Georgia and 136 in New Jersey), 413 subscriptions to THE JOURNAL, and thirty-nine subscriptions to special journals were secured in these two states.

The total number of copies of THE JOURNAL printed in 1924 was 4,410,220, which was 176,888 more than in 1923.

The gross weekly average for 1924 was 84,811, or 3,401 more than in 1923.

The average weekly paid circulation in 1924 was 81,257, which represents an increase of 3,678 over 1923.

The total number of Fellows on the mailing list, Jan. 1, 1925, was 52,238, an increase of 2,063 over 1924. The total number of subscribers other than Fellows was 32,562, as against 30,122 at a corresponding time in the preceding year. The Fellowship figures here given do not include honorary and associate Fellows, commissioned officers of government services, or those Fellows who have substituted one of the special publications of the Association for THE JOURNAL.

Table A, which follows, presents an approximate count of Fellows and subscribers on the mailing list, Dec. 31, 1924, and shows the gain or loss over the previous year:

TABLE A.—*Approximate Count of Fellows and Subscribers on Mailing List on Dec. 31, 1924; Also Gain or Loss Over the Previous Year*

State	Fellows	Subscribers	Totals	Gain for Year	Loss for Year
Alabama	477	365	842	57	..
Arizona	163	96	259	26	..
Arkansas	467	233	700	27	..
California	3,064	1,947	5,011	212	..
Colorado	665	338	1,003	...	22
Connecticut	722	500	1,222	11	..
Delaware	84	45	129	...	3
District of Columbia	404	384	788	110	..
Florida	373	264	637	38	..
Georgia	810	467	1,277	...	11
Idaho	149	86	235	...	11
Illinois	5,141	2,423	7,564	580	..
Indiana	1,466	706	2,172	131	..
Iowa	1,448	481	1,929	11	..
Kansas	874	390	1,264	...	22
Kentucky	750	410	1,160	92	..
Louisiana	648	294	942	19	..
Maine	368	180	548	53	..
Maryland	786	483	1,269	...	27
Massachusetts	2,643	1,288	3,931	156	..
Michigan	1,712	1,125	2,837	266	..
Minnesota	1,258	681	1,939	144	..
Mississippi	296	214	510	36	..
Missouri	1,969	899	2,868	91	..
Montana	149	159	308	1	..
Nebraska	686	458	1,144	51	..
Nevada	65	25	90	2	..
New Hampshire	276	75	351	16	..
New Jersey	1,507	986	2,493	414	..
New Mexico	138	71	209	...	1
New York	6,304	3,838	10,142	635	..
North Carolina	588	410	998	25	..
North Dakota	246	99	345	...	22
Ohio	2,750	1,677	4,427	382	..
Oklahoma	677	314	991	10	..
Oregon	343	293	636	21	..
Pennsylvania	4,529	2,355	6,884	199	..
Rhode Island	294	155	449	22	..
South Carolina	382	280	662	...	68
South Dakota	216	158	374	6	..
Tennessee	678	424	1,102	88	..
Texas	1,720	757	2,477	165	..
Utah	215	105	320	...	3
Vermont	184	127	311	24	..
Virginia	693	487	1,180	46	..
Washington	622	414	1,036	26	..
West Virginia	572	319	891	4	..
Wisconsin	1,235	636	1,871	71	..
Wyoming	94	70	164	..	..
U. S. Army	...	192	192	5	..
U. S. Navy	...	275	275	50	..
U. S. P. H. S.	...	...	...	50	75
Alaska	14	11	25	...	..
Canada	21	932	953	199	..
Shanghai	...	...	...	...	40
Cuba	6	44	50	5	..
Hawaii	48	52	100	16	..
Mexico	19	89	108	...	..
Panama	22	23	45	...	8
Philippine Islands	46	123	169	27	..
Porto Rico	30	33	63	...	5
Virgin Islands	...	...	...	...	2
Foreign	132	1,797	1,929	253	..

Table B gives the number of physicians (based on the eighth edition of the American Medical Directory) in the United States, the number receiving THE JOURNAL, and the approximate percentage in each state. (Copies sent to physicians in the United States Army, Navy and Public Health Service, etc., not included.)

TABLE B.—*Percentage of Physicians Receiving The Journal*

State	Number Receiving JOURNAL	Phyicians in State 8th A. M. A. Directory	Approximate Percentage 8th A. M. A. Directory
Alabama	842	2,313	36
Arizona	259	372	69
Arkansas	700	2,303	30
California	5,011	7,549	66
Colorado	1,003	1,882	53
Connecticut	1,222	1,727	71
Delaware	129	265	49
District of Columbia	788	1,924	41
Florida	637	1,348	47
Georgia	1,277	3,274	39
Idaho	235	452	52
Illinois	7,564	10,716	71
Indiana	2,172	4,353	50
Iowa	1,929	3,490	55
Kansas	1,264	2,492	51

TABLE B.—*Continued.*

State	Number Receiving JOURNAL	Physcians in State 8th A. M. A. Directory	Approximate Percentage 8th A. M. A. Directory
Kentucky	1,160	3,155	37
Louisiana	942	2,058	46
Maine	548	1,067	51
Maryland	1,269	2,349	54
Massachusetts	3,931	5,977	66
Michigan	2,837	4,653	61
Minnesota	1,939	2,774	70
Mississippi	510	1,792	28
Missouri	2,868	5,827	49
Montana	308	568	54
Nebraska	1,144	1,913	59
Nevada	90	140	64
New Hampshire	351	615	57
New Jersey	2,493	3,362	74
New Mexico	209	399	52
New York	10,142	16,857	60
North Carolina	998	2,226	45
North Dakota	345	517	67
Ohio	4,427	8,086	56
Oklahoma	991	2,600	38
Oregon	636	1,158	55
Pennsylvania	6,884	11,241	61
Rhode Island	449	754	60
South Carolina	662	1,368	49
South Dakota	374	630	59
Tennessee	1,102	3,228	34
Texas	2,477	6,094	41
Utah	320	497	64
Vermont	311	556	56
Virginia	1,180	2,503	47
Washington	1,036	1,756	59
West Virginia	891	1,751	51
Wisconsin	1,871	2,772	67
Wyoming	164	263	62

ADVERTISING DEPARTMENT

The receipts from the sale of advertising space for the year 1924 was $614,084.67, which sum represents a decrease of $3,740.37 as compared with the receipts for 1923, or a reduction of about three fifths of 1 per cent. Since the best available information indicates that there was a general tendency toward reduction in advertising in practically all classes of publications during the year covered by this report, this is a thoroughly satisfactory showing.

The receipts from advertising exceeded those from Fellowship dues and subscriptions by $195,347.49. It is to be remembered that the reduction in Fellowship dues and subscription to THE JOURNAL from $6 to $5 was in effect in 1924, and that the gross income on this account was thereby very materially lessened.

The advertising pages of THE JOURNAL have been censored during the year as heretofore, by the Advertising Committee. A very considerable volume of advertising has been offered and refused because the Committee considered it unacceptable. One or two fairly large contracts have been canceled because the advertisers refused to comply with the rules of THE JOURNAL.

COOPERATIVE MEDICAL ADVERTISING BUREAU

The commissions rebated to the state journals by this bureau amounted to $5,500. The Cooperative Medical Advertising Bureau is now serving thirty-one journals, which number includes all of the state medical journals with a single exception. It is believed that the service rendered by this bureau is very helpful to these journals, and expressions received from their editors and publishers indicate that it is thoroughly appreciated.

SPANISH EDITION

The mailing list of the Spanish Edition of THE JOURNAL, Dec. 31, 1924, contained 2,599 names, which was sixty-eight less than on the corresponding date of the preceding year. The accompanying table shows the distribution in the countries named.

Under the agreement in force with the Rockefeller Foundation, half of the net loss on the publication of the Spanish Edition, amounting to $12,902.05, was charged to the Foundation and has been duly paid. In addition, the Rockefeller Foundation has borne the cost of exchange, due to the depreciation of the monies of countries in which this publication finds circulation. This amounted to $2,537.60.

There can be little doubt that good fellowship has been promoted between the medical profession of Spanish American countries and that of the United States by the publication of the Spanish Edition. Other publications of the American Medical Association have been brought to the fore among the Latin-American profession. A knowledge of the organization of the American Medical Association may have had some influence with respect to the development of medical organizations in these countries: In Argentina, the creation of a Council on Pharmacy and Chemistry has been discussed, and local medical societies have been organized in the smaller centers.

Distribution of the Spanish Edition

Africa	1
Argentina	355
Bolivia	44
Brazil	194
Chile	101
Colombia	79
Costa Rica	21
Cuba	396
Dominican Republic	18
Ecuador	23
England	1
France	3
Germany	2
Guatemala	55
Honduras	20
Italy	4
Mexico	398
Nicaragua	15
Panama	9
Paraguay	4
Peru	92
Philippine Islands	160
Porto Rico	42
Portugal	12
Salvador	51
Spain	209
Sweden	1
United States	59
Uruguay	71
Venezuela	40

SPECIAL JOURNALS

The circulation of the special journals for 1924 was as follows: ARCHIVES OF INTERNAL MEDICINE, 2,757, a gain of 275 over the circulation of the preceding year; AMERICAN JOURNAL OF DISEASES OF CHILDREN, 3,108, a gain of 338; ARCHIVES OF NEUROLOGY AND PSYCHIATRY, 1,274, a gain of twenty-six; ARCHIVES OF DERMATOLOGY AND SYPHILOLOGY, 1,394, a gain of eighty; ARCHIVES OF SURGERY, 2,169, a loss of fifty-seven.

The ARCHIVES OF OTOLARYNGOLOGY made its appearance, Jan. 15, 1925, with a subscription list of 2,121, which has been materially increased since that time.

This new journal has been well received, as is attested by the number of subscriptions and by the many favorable comments offered. Dr. G. E. Shambaugh, Chicago, chairman, and Drs. Chevalier Jackson, Isidor Friesner, Eugene A. Crockett, Robert C. Lynch and Greenfield Sluder are the members of the Editorial Board.

The profit and loss on these special journals for 1924 is shown in the table:

Internal Medicine	Gain	$1,152.60
Children's Journal	Gain	2,611.56
Surgery	Gain	892.25
Neurology and Psychiatry	Loss	1,135.03
Dermatology and Syphilology	Loss	2,742.42

Constant effort is being made to improve the quality of this group of the Association's publications. In order that plans intended to make such effort successful may be carried out, it has been necessary to increase the subscription price of some of them, namely, the ARCHIVES OF SURGERY, the ARCHIVES OF NEUROLOGY AND PSYCHIATRY, and the ARCHIVES OF DERMATOLOGY AND SYPHILOLOGY from $6 to $8.

After the end of the current volume, it is proposed that the ARCHIVES OF SURGERY shall be issued as a monthly, rather than as a bimonthly publication.

QUARTERLY CUMULATIVE INDEX

The circulation of the QUARTERLY CUMULATIVE INDEX for 1924 was 1,212. This shows only a slight increase over 1923—a gain of eleven subscribers. That this publication has established itself as an important accessory to scientific progress is shown in the fact that it is receiving more and more commendation at the hands of medical writers, research workers and librarians.

The net cost of the QUARTERLY CUMULATIVE INDEX for 1924 was $11,388.58, which is more by the sum of $3,295.64 than in

1923. This, of course, is due in great part to the fact that the number of journals indexed is gradually being enlarged, and the quality of the publication generally improved. Careful consideration has been given to the possibility of reducing the costs of this publication, but up to this time no plan has been devised which gives promise of securing any such result.

The QUARTERLY CUMULATIVE INDEX is extremely helpful, not only in that it provides, for the benefit of its subscribers and a a large number of institutions, a splendid index to scientific literature appearing in nearly three hundred leading medical journals, but also because it meets the demands of the various bureaus and departments of the Association which require that an up-to-date index on medical literature shall always be at hand.

Because of the enlargement of the INDEX and the consequent growing cost of publication, the subscription price has been placed at $8 instead of $6.

AMERICAN MEDICAL DIRECTORY

The investment in the Ninth Edition of the Directory to Dec. 31, 1924, amounted to $53,565.86, and this sum was, of course, considerably augmented by the cost of labor, printing, binding, etc., before the Directory was ready for distribution. The latter charges will appear in the financial report to be submitted at the next Annual Session.

While some economies have been effected, there has been unusual expense attached to the publication of the Ninth Edition, owing to the necessity for preparing a complete set of new master cards, and to innovations introduced for the purpose of making the Directory more accurate and complete.

The number of advance orders for the Ninth Edition received prior to Jan. 1, 1925, was 5,681, which exceeds the number of orders at a corresponding date prior to the issuance of the Eighth Edition. A very satisfactory number of subscriptions has been received since that time.

The American Medical Directory never has been produced without a loss, and it is not probable that it ever can be. It has, however, become an established institution of great value to the Association itself, as well as to the medical profession and to those with whom physicians must have business dealings. Through the publication of the Directory, it is possible for the various councils, bureaus and departments of the Association to have at hand information that is invaluable and necessary in their daily operations. The Directory and the files of the Biographic Department constitute an almost complete record of the medical profession in the United States and its territorial possessions, and in Canada; nowhere else is this record being maintained.

The maintenance of the biographic records of the Association involves tremendous labor and large expense. Some idea may be had of the amount of work necessary to keep these records accurate when it is remembered that from 600 to 650 changes in the mailing list of THE JOURNAL alone must be made each week. There can be no doubt, however, as to the value of the Biographic Department, nor as to the value of the Directory itself, which represents a very distinct contribution on the part of the American Medical Association to the profession of the United States and of Canada.

ORDER DEPARTMENT

The report of the Order Department for 1924 shows that 57,259 orders for publications and products of the Association, aside from its journals, were handled by this department during the year. This represents a gain over the number of orders handled in 1923 of more than 17,000 and shows the increase of the use of the pamphlets published by the Association. Baby welfare pamphlets were the leaders in sales, 154,115 of these pamphlets having been disposed of during the year, while periodic health examination forms were distributed to the number of 61,900.

HYGEIA

HYGEIA is slowly but steadily gaining favor, and in the fact that its circulation has now gone above the thirty thousand mark, there may be found a reasonable basis for encouragement with regard to its final success. If we are to accept at their face value the favorable comments that have appeared in state medical journals and bulletins, in the lay press, and in large numbers of letters received, we must believe that HYGEIA is considered to be helpful, not only to the public, but also to the medical profession. By far the greatest number of comments made in personal communications have been commendatory; in fact, unfavorable criticisms have been received only occasionally.

Everywhere, the purpose of HYGEIA is lauded, and the American Medical Associaiton is given credit for a worthy effort in behalf of the public. It is particularly gratifying that teachers in practically all parts of the country have indicated their appreciation of HYGEIA, and have informed us that they are making daily use of the magazine in their classroom work.

The clip sheets, which have been widely distributed, have been used extensively in the lay press, sometimes on the initiative of the editors of newspapers and frequently on the initiative of medical societies. Some of the most widely circulated lay magazines have made favorable comment on HYGEIA and its purpose, as well as on its content and its editorial policies.

The Editorial Board has recently effected some economies which it is hoped can be applied throughout the year, and thus reduce, to some extent, the expense of securing material for publication, as well as mechanical costs.

The spirit that has been exhibited by contributors to the columns of HYGEIA has been one that deserves the grateful appreciation of the members and officers of the Association. While many of these receive rather large sums for their writings for other periodicals, they have been very generous in their dealings with HYGEIA.

CIRCULATION

The total number of subscribers in each state, Dec. 31, 1924, divided into two classes—physicians and laity—is shown in the appended table:

State	Physicians	Laity	Total
Alabama	97	125	222
Arizona	72	158	230
Arkansas	113	107	220
California	694	826	1,520
Colorado	197	178	375
Connecticut	177	144	321
Delaware	21	22	43
District of Columbia	144	102	246
Florida	84	72	156
Georgia	108	120	228
Idaho	62	53	115
Illinois	1,074	1,313	2,387
Indiana	443	573	1,016
Iowa	518	596	1,114
Kansas	301	339	640
Kentucky	127	97	224
Louisiana	117	196	313
Maine	81	93	174
Maryland	143	118	261
Massachusetts	441	449	890
Michigan	570	562	1,132
Minnesota	335	445	780
Mississippi	78	96	174
Missouri	385	373	758
Montana	48	61	109
Nebraska	217	256	473
Nevada	19	13	32
New Hampshire	46	36	82
New Jersey	257	233	490
New Mexico	36	39	75
New York	1,349	1,105	2,454
North Carolina	133	159	292
North Dakota	64	87	151
Ohio	621	783	1,404
Oklahoma	134	156	290
Oregon	106	139	245
Pennsylvania	1,223	1,028	2,251
Rhode Island	62	52	114
South Carolina	73	69	142
South Dakota	74	95	169
Tennessee	158	159	317
Texas	343	345	688
Utah	71	126	197
Vermont	39	64	103
Virginia	169	268	437
Washington	172	242	414
West Virginia	124	175	299
Wisconsin	281	945	1,226
Wyoming	25	43	68
Possessions	57	83	140
Canada	82	148	230
Foreign	128	168	296
Navy	...	300	300
Advertising	...	41	41
Exchange	...	53	53
Complimentary	...	142	142
Agents	...	26	26
	12,493	14,796	27,289*

* This statement was prepared so that it might be had very early in the current year, and a number of subscriptions in hand were not included.

The most difficult problems that have been met in connection with the publication of HYGEIA are those which are common to all new magazines; namely, the securing of new subscriptions and the stabilizing of the circulation. It is gratifying to report that, with respect to both new subscriptions and renewals, each week shows some improvement over the record of the preceding year. The circulation among laymen has shown a very considerable increase.

Gains in circulation were made in thirty-nine states. Wisconsin registered the largest increase: in 1923, there were 464 subscribers in that state, while in 1924 the number increased to 1,226.

The question is frequently raised as to why HYGEIA is not more readily available at news stands throughout the country. Under present conditions, the cost of placing HYGEIA on the news stands generally would be prohibitive. Arrangements have been made with the American News Company whereby any news stand in the United States can secure HYGEIA on order, as well as for news stand distribution through local dealers in some cities.

The net loss on HYGEIA for nine months in 1923 was $38,989.64, while the net loss in the twelve months of 1924 was $42,745.14. The average monthly loss, therefore, was considerably less than in 1923. Earnest thought has been given by everybody concerned with the publication of HYGEIA to the possible reduction of production costs. As has already been stated in this report, the Editorial Board has effected considerable saving in the cost of contributed articles and with respect to the mechanical make-up of the magazine. It is felt that it would be a mistake to lower the quality of the publication, either as to its content or as to its mechanical make-up. From a printing standpoint, it is not believed that any periodical published is superior to HYGEIA.

It is apparent that HYGEIA will be published at considerable expense to the Association until such time as its circulation has been so increased as to make it a desirable advertising medium. The probability is that the income derived from subscriptions never will be sufficient to defray more than a small part of publication expense. This is true of the more successful periodicals, even of those having a circulation of millions, and there is no reason to believe that HYGEIA can be made an exception in this respect.

While it is intended that all possible methods shall be applied that will reduce promotion and publication costs, it is yet very difficult to see how any marked reductions can be effected at the present time. It will therefore be necessary, in any plans that may be adopted for producing income sufficient to enable the Association to carry on its various worthy activities, to consider HYGEIA as a very important factor in the situation.

THE BUREAU OF INVESTIGATION

The interest of the medical profession and of the public in the work of the Bureau of Investigation (Propaganda Department) continues to increase. There was a small decrease in the number of letters received by the bureau from physicians during 1924. This, however, was to be expected; in the two preceding years, the interest of the profession was stimulated to an uncommon degree by the Abrams quackery, which then had its vogue, and numerous inquiries were received from physicians concerning it. On the other hand, more letters were received from laymen during the year than ever before in the history of the organization; in fact, the inquiries received from laymen and from physicians were almost equal in number.

It will be noted that the name "Propaganda Department" has been superseded by the more descriptive term, "Bureau of Investigation." This change was made because it was felt that the new name more accurately describes the activities of that department of the Association's work than the older term, "Propaganda Department." At the time that the name "Propaganda for Reform in Proprietary Remedies" was first applied, it fully and accurately described the functions of the department that bore the name. During those years, propaganda was truly needed. The acute need has passed and the work of the Bureau of Investigation covers a broader and a more general field in its attempt to give to the profession and the public information regarding nostrums, quacks, pseudomedicine and allied subjects.

The bureau has done a large and important work in furnishing the Associated Advertising Clubs and its affiliated bodies with information regarding quacks and "patent medicines." The Better Business Commission of Buffalo has been furnished a veritable encyclopedia on the subject of local quacks and locally exploited nostrums. On the basis of the information furnished, plus their own personal investigation, the Buffalo advertising men have carried out an active drive against the more blatant quacks and nostrum venders. This drive has stimulated the local authorities to act, and the work accomplished has been both in the interest of truth in advertising and, more important from our standpoint, a valuable contribution to the public health. Such work is being conducted all the time in the various large centers, and the bureau is exerting, and has for some years exerted, a silent but far-reaching influence that can be appreciated only by those who are thoroughly familiar with its daily work.

Calls continue to come from schools and colleges, from both pupils and teachers, for information on the "patent medicine" evil. The work that the bureau has done in the past in furnishing authoritative information for authors of school and college textbooks on general science, civic science, biology, hygiene, etc., is making itself felt in the increased interest exhibited from those sources.

The Bureau of Investigation renders an exceptional service to the individual physician, as is shown by the fact that hundreds of inquiries are answered from physicians in every state in the Union. The educational value of the letters that go out from this bureau is tremendous: The physician is constantly called on to reply to queries propounded by patients, involving definite information which he does not possess. He therefore writes to the Bureau of Investigation, and secures, by return mail if feasible, a letter presenting the information sought. In most instances, the letter is accompanied with a pamphlet on the subject of inquiry, which can be put into the hands of the patient. Many letters are received by the bureau from physicians who wish to secure material to serve as the basis of informative talks before lay organizations, and such requests are immediately complied with whenever it is at all possible. The bureau is provided with a certain amount of exhibit material which is in more or less constant demand, and physicians are more and more availing themselves of this source of supply.

These are instances of the kind of service that is rendered by the Bureau of Investigation to the members of the medical profession, in addition to the work of preparing material for publication in THE JOURNAL. The files of the bureau are full of material that cannot be duplicated elsewhere in the world, and this is being used to the best possible advantage.

COUNCIL ON PHARMACY AND CHEMISTRY

The work of the Council on Pharmacy and Chemistry has been prosecuted along the lines that have been followed in previous years. Practically all the large producers of pharmaceuticals now find it possible and desirable to recognize the work of this Council.

One of the outstanding problems with which the Council now has to deal is that connected with the exploitation of the so-called endocrine preparations and pluriglandular mixtures.

Among those who have rendered valuable aid to the Council during the past year are the writers of a series of articles, published under the auspices of the Council, on Glandular Therapy: F. G. Banting, Frank Billings, Walter M. Boothby, A. J. Carlson, Henry A. Christian, C. W. Edmunds, D. R. Hooker, W. H. Howell, Reid Hunt, Edward C. Kendall, Graham Lusk, W. G. MacCallum, J. J. R. Macleod, William S. McCann, Joseph L. Miller, Emil Novak, Henry S. Plummer, Edward P. Richardson, Torald Sollmann, Joseph T. Wearn, Russell M. Wilder and J. Whitridge Williams. In addition, the valued assistance received from P. J. Hanzlik and the Leland Stanford University School of Medicine, H. N. Cole and the Western Reserve University School of Medicine, and from E. M. Bailey and the Connecticut Agricultural Experiment Station deserves special mention.

The members of the Council work unselfishly and without remuneration. Most of them have served since the establishment of the Council, and the entire membership is deserving of the appreciation of the medical profession, which can best be shown by a consistent practical endorsement of the Council's work.

Therapeutic Research Committee

The activities of the Therapeutic Research Committee of the Council on Pharmacy and Chemistry are expended mainly along the following lines:

A. *The Organization of Therapeutic Research Requiring Collaboration:*

Work in this field is illustrated by the recent report of the Special Committee on The Toxic Effects Following the Use of Local Anesthetics (J. A. M. A., March 15, 1924, p. 876).

A Committee for the Study of Intravenous Therapy has been organized, with Dr. Cary Eggleston as chairman.

B. *Support of Investigations of Problems of Special Interest to the Council:*

Work of this type is supported by the Therapeutic Research Committee when competent investigators may be secured, but almost inevitably much of it gravitates to the laboratories of those who are most interested in the topics proposed; thus, a considerable proportion of such work is performed under the immediate direction of the Chairman of the Therapeutic Research Committee. The grants that are made in this connection cover only a small part of the cost of the investigations, and go to pay for materials and apparatus required.

C. *Support of Problems Submitted Independently:*

This has taken the form of contributions toward the material expenses of investigations that were somewhat beyond the ordinary budgets of the laboratories of the investigators. The investigations conducted under the Therapeutic Research Committee published during 1924 were as follows:

Organic, Protein and Colloidal Silver Compounds. II. Their Antiseptic Efficiency in Body Fluids Rich in Cells and Protein (Defibrinated Blood), J. D. Pilcher and Torald Sollmann, *Journal of Laboratory and Clinical Medicine*, January, 1924.

Organic, Protein and Colloidal Silver Compounds. III. Does the "Colloidal Silver" Become Available as Antiseptic? Torald Sollmann and J. D. Pilcher, *Journal of Laboratory and Clinical Medicine*, October, 1924.

Organic, Protein and Colloidal Silver Compounds. IV. Deterioration of Solutions on Keeping, Torald Sollmann and J. D. Pilcher, *Journal of Laboratory and Clinical Medicine*, November, 1924.

The Clean Inunction Treatment of Syphilis with Mercury, H. N. Cole, J. G. Hutton and Torald Sollmann, The Journal A. M. A., Jan. 19, 1924.

The Use of Arsphenamin and Its Derivatives Administered by Rectum, Sidney Littmann and J. G. Hutton, The Journal A. M. A., March 15, 1924.

The Toxic Effects Following the Use of Local Anesthetics, Emil Mayer, The Journal A. M. A., March 15, 1924.

Further Observations on Anaphylactoid Phenomena from Various Agents Injected Intravenously, Paul J. Hanzlik and Howard T. Karsner, *Journal of Pharmacology and Experimental Therapeutics*, April, 1924.

Treatment of Anaphylactoid Phenomena from Some Agents by Hypertonic Sugar and Salt Solutions, Paul J. Hanzlik and Howard T. Karsner, *Journal of Pharmacology and Experimental Therapeutics*, April, 1924.

Effects from the Intraperitoneal Injection of Various Agents Causing Anaphylactoid Phenomena, Paul J. Hanzlik and Howard T. Karsner, *Journal of Pharmacology and Experimental Therapeutics*, April, 1924.

The Skin-Reaction to Morphin, J. D. Pilcher and Torald Sollmann, Archives of Internal Medicine, April, 1924.

Metallic Mercury Suspensions, H. N. Cole, J. G. Hutton, John Rauschkolb and Torald Sollmann, The Journal A. M. A., Aug. 23, 1924.

The Extraction and Some Properties of an Ovarian Hormone, Edward A. Doisy and J. O. Ralls and Edgar Allen and C. G. Johnston, *Journal of Biological Chemistry*, October, 1924.

A Microscopic Study of Mercury Absorption from the Skin, Karl G. Zwick, The Journal A. M. A., Dec. 6, 1924.

Grants issued before Jan. 1, 1924, to apply on work which is not yet completed or published were as follows:

Grant 80: H. N. Cole, associate professor of dermatology, Western Reserve University School of Medicine, $200, to investigate the excretion of mercury with various methods of administration.

Grant 83: Charles W. Greene, professor of physiology and pharmacology, University of Missouri School of Medicine, $250, to investigate the distribution of nitrous oxid and oxygen in the blood during anesthesia.

Grant 88: M. S. Dooley, professor of pharmacology, Syracuse University College of Medicine, $75, to aid in the completion of an investigation on a comparison of the results of intramuscular injections in the frog of various preparations of digitalis, with colorimetric assays of the same.

Grants issued during 1924:

Grant 89: H. G. Barbour, professor of physiology and pharmacology, Louisville University School of Medicine, $150, to investigate the trypanocidal effect of certain aliphatic arsenicals.

Grant 90: H. N. Cole, associate professor of dermatology, Western Reserve University School of Medicine, $100, to investigate the intravenous injection of metallic mercury.

Grant 91: E. A. Doisy, professor of biological chemistry, St. Louis University School of Medicine, $500, to investigate the isolation and study of the properties of the active constituent of the ovary.

The Chemical Laboratory

The Chemical Laboratory, having been installed in permanent quarters in the new building, was able to work to much greater advantage during the latter part of 1924 than during the period when building operations were in progress. The laboratory is now better equipped and better housed than ever before, and its personnel has been increased by the addition of an assistant chemist.

Close contact is maintained by the Laboratory with the Council on Pharmacy and Chemistry and with the Bureau of Investigation, and a very considerable amount of work is being done in the Laboratory at the instance of these two departments. The Laboratory also serves The Journal, other bureaus and departments of the Association, and replies to numerous inquiries received from the officers and members of the Association. Some original investigations have been undertaken which give promise of producing valuable results.

During the past year, the Laboratory has elaborated for the Council on Pharmacy and Chemistry standards for practically all synthetic products submitted. It has questioned the chemical constitution of other synthetics, and manufacturers have been benefited by suggestions emanating from the laboratory, with the result that some of the newer products have been improved.

Analyses have been made for the Bureau of Investigation which form the basis of articles appearing in The Journal and in Hygeia. An investigation of the various bismuth compounds used in syphilis is now nearly complete. One member of the Laboratory staff, in collaboration with the Association of Agriculture and with official chemists, has worked out standards for chaulmoogra oil.

The Library

The work done in the Library of the Association is much greater in amount and in scope than is generally realized. The Library is essentially a reference storehouse of current medical literature. The number of books on its shelves is not large, but more than 250 of the leading medical journals of the world are on file. More than twelve hundred inquiries were answered last year, not taking into consideration those which came by telephone or those submitted by the personnel in the Association offices. In addition to a relatively large increase in bibliographic work, there has been a marked increase in the lending of periodicals, as the result, in part, of the extension of the library service to include domestic journals. In 1923, 475 journals, and in 1924, 760 were lent to physicians.

The package library service, instituted in 1924, has not yet been perfected, but material for it is constantly being collected, and the demands for this service have constantly grown. In many instances, those who have received packages have written very commendatory letters of appreciation.

The Library personnel is called on to do a great deal of work in preparing indexes. The biggest part of this work is involved in the preparation of the Quarterly Cumulative Index to Current Medical Literature, which has grown within eight years from a volume of 283 pages to one of 900 pages. Seventy-eight other indexes were prepared in the Library in 1924, and this number will be increased to eighty-one during the current year.

For the benefit of the employees of the Association, a circulating library is maintained, in close cooperation with the Chicago Public Library.

COMMITTEE ON SCIENTIFIC RESEARCH

NEW GRANTS

Since the last report, the following grants have been made from the $2,000 appropriated by the Trustees in the early part of this year and funds already available as a balance left over from the preceding year:

Grant 68: $200 to J. F. McClendon, Department of Physiology, University of Minnesota, for purchase of precision wave meter to be used in the study of the electrical conductivity of living cells.

Grant 69: $400 to Linda B. Lange, School of Hygiene and Public Health, Johns Hopkins University, to aid in the study of the influence of diet in experimental tuberculosis.

Grant 70: $200 to R. A. Spaeth, School of Hygiene and Public Health, Johns Hopkins University, for continuation of work on the influence of fatigue on infection, for which purpose Grants 55 and 63, each of $200, were made previously.

Grant 71: $400 to H. M. Evans, Department of Anatomy, University of California, toward the study of the hormone of the anterior part of the hypophysis.

Grant 72: $250 to V. C. Jacobson, Albany Medical College, for the study of so-called implantation adenomas of pelvic organs.

Grant 73: $200 to Charles E. Simon, School of Hygiene and Public Health, Johns Hopkins University, to aid in work on experimental measles, for which purpose Grant 67, $100, was made previously.

Grant 74: $300 to Thomas Addis, Division of Medicine, Stanford University, for study of compensatory renal hypertrophy.

Grant 75: $200 to Victor Burke, Department of Bacteriology, State College of Washington, for investigation of the value of dye treatment of infections.

All these new grants have been paid in full, and, as stated farther on, the work in each case has been completed or is in active progress.

STATUS OF WORK

The status of work still pending under new and previous grants may be summarized briefly, as follows:

Grant 39: $1,000 (unpaid balance $400) to E. O. Jordan, University of Chicago, for critical review of the literature on the influenza epidemics of 1918 and 1919, with synopsis of results achieved. This important work, which was undertaken on the invitation of Dr. George H. Simmons and the Committee on Scientific Research, is being put into shape for publication. It is believed that it will be ready by the end of next summer.

Grant 52: $400 to W. H. Welker, University of Illinois, for the chemical study of bacterial proteins. The work under this grant is nearly completed.

Grant 53: $300 to F. P. Underhill, Yale University, for study of metabolism of inorganic salts. One article giving results of this work has been published in the *Journal of Biological Chemistry;* further publications will be made. Of this grant, $270 was used for the purchase of platinum crucibles, which, according to the rules, are the property of the American Medical Association.

Grant 54: $350 to Albert Keidel, Johns Hopkins Hospital, for investigation on the occurrence of *Spirochaeta pallida* in the arachnoid fluid in the early stages of syphilis, conducted by Drs. Chesney and Kemp. This work has been completed, full account of the expenditures has been made, and the results have been published in THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, Nov. 29, 1924.

Grants 55, 63 and 70: $600 in all to R. A. Spaeth, Johns Hopkins School of Public Health: for fatigue and infection. This work has been concluded and the results will be published in the *American Journal of Hygiene.* Full accounts of all expenditures have been rendered, and the unused balance, $144.52, has been refunded.

Grants 57 and 61: $369.46 to Yandell Henderson, Yale University, for kymograph. According to the rules, this instrument is the property of the Association, and a brass plate on the instrument so states. An article entitled "Maximum of Human Power," in which are given the results of an extensive study in which this instrument was used of the respiration and energy expenditures of athletes has been submitted to THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

Grant 58: $225 to E. B. Krumbhaar, Philadelphia General Hospital, for the study of inguinal granuloma. This work has been completed, the results published, and full account rendered of the expenses.

Grant 59: $225 to F. W. Mulsow, University of Iowa: culture mediums for the gonococcus. This work has been finished, the results are being published, and account has been rendered of the expenses.

Grants 60 and 71: Each grant for $40, to H. M. Evans, University of California, for study of endocrine glands. The work, now in progress, deals with the hormones in the anterior lobe of the hypophysis.

Grant 62: $150 to A. C. Ivy, University of Chicago: stimulation of gastric secretions by amino-acids and amins. This work has been completed, and the results will be published in the *American Journal of Physiology.*

Grant 64: $200 to E. R. LeCount, Rush Medical College: tuberculosis and mitral disease. This work is nearing completion.

Grant 65: $300 to L. E. Hines, St. Joseph's Hospital, Chicago: intestinal flora in diarrhea. This work has been completed and the results have been published.

Grant 66: $250 to H. G. Rowell, New Bedford and Columbia University: nutrition studies in children. This work has been completed, the results are being published, and full account has been rendered of expenses. A refund of $36.76 has been made in the case of this grant.

Grants 67 and 73: $300 in all to Charles E. Simon, Johns Hopkins University, for studies in experimental measles. This work has been completed and the results have been published.

Grant 68: $200 to J. F. McClendon, University of Minnesota, for precision wave meter for use in the study of the electrical conductivity of living cells. According to the rules, this instrument is the property of the Association. A short report on the results obtained has been published in *Science,* and further work is in progress.

Grant 69: $400 to Linda B. Lange, Johns Hopkins University: diet in experimental tuberculosis. Work in progress.

Grant 72: $250 to V. C. Jacobson, Albany Medical College: implantation adenomas of the pelvic organs. Part of this grant has been used for the purchase of monkeys and other animals for experimental work, the results of which will be learned after several months.

Grant 74: $300 to Thomas Addis, Stanford University: compensatory renal hypertrophy. The grant is being used largely for casein, lard, cod liver oil and other substances necessary for the food of the large number of rats used in the experiments.

Grant 75: $200 to Victor Burke, State College of Washington: dye treatment of infections. Active work is in progress, with promise of interesting results.

APPLICATIONS ON HAND

The following applications have been received:

For $500, from Harry L. Huber, University of Chicago, to enable him to carry on a study of the chemistry of pollens, for the purpose of determining the chemical elements concerned in hay-fever and similar processes.

For $500, from Arthur M. Yudkin, New Haven, Conn., toward an experimental study on the formation of cataract and related ocular changes, the money to be used for the purchase of animals, food and technical assistance. This work will be carried out in the laboratories of Yale University.

For from $250 to $400, from A. W. Meyer, Stanford University, to aid in a study of polyneuritis in guinea-pigs caused by special diet.

FINANCIAL STATEMENT

Balance to credit of committee, Jan. 1, 1924	$ 900.04	
Appropriation for 1924	2,000.00	
		$2,900.04
Refund, H. G. Rowell, Grant 66	$ 36.76	
Refund, R. A. Spaeth, Grants 55, 63 and 70	144.52	
		$ 181.28
		$3,081.32

GRANTS PAID IN 1924

Grant 62, A. C. Ivy, balance	$ 100.00
Grant 64, E. R. LeCount	175.00
Grant 68, J. F. McClendon	200.00
Grant 69, Linda B. Lange	400.00
Grant 70, R. A. Spaeth	200.00
Grant 71, H. M. Evans	400.00
Grant 72, V. C. Jacobson	250.00
Grant 73, Charles E. Simon	200.00
Grant 74, Thomas Addis	300.00
Grant 75, Victor Burke	200.00
	$2,425.00
Balance to credit of committee	656.32
Grant 39, E. O. Jordan, unpaid balance	400.00
Unallotted balance	$ 256.32

RETROSPECT AND COMMENTS

The first appropriation by the Trustees of the American Medical Association to aid scientific research was made in 1903. Annual appropriations have been made each year since about that time, except in the years 1915, 1916 and 1917. The amount appropriated each year has risen from $500 at first to $2,000 for 1924, and the total amount appropriated since 1903 is approximately $17,000. The money has been used for grants in aid of medical research, and especially in aid of meritorious work that otherwise might not have been undertaken. In all, seventy-five grants have been made in sums of from $50 to $1,000, in most cases of from $200 to $300. It is gratifying that, without exception, the grants can be said to have been used to good advantage, as shown in the preceding complete record of grants. In each instance the work undertaken has been carried out at least to the extent that results worthy of publication in standard medical journals have been obtained. Undoubtedly, the resulting benefits, direct as well as indirect, fully justify the expenditures. In only one instance has a grant been canceled, and this was done before the grant had been paid and at the request of the grantee.

In conclusion, it may be pointed out that the eight applications granted this year (Grants 68 to 75) represent about one half of the applications received, and that several meritorious applica-

tions had to be refused for lack of funds. In all these cases, the money is being used for special assistance, supplies and equipment; in no case for the salary of the worker.

Committee on Scientific Grants

G. N. Stewart, Cleveland, term expires 1925.
Ludvig Hektoen, Chicago, Chairman, 1926.
C. C. Bass, New Orleans, 1927.
Charles A. Frazier, Philadelphia, 1928.
Noble Wiley Jones, Portland, 1929.

Respectfully submitted.

LUDVIG HEKTOEN, Chairman,
Committee on Scientific Grants.

BUREAU OF HEALTH AND PUBLIC INSTRUCTION

This bureau is turned to for information, advice and educational material by many organizations, groups and individuals, both medical and lay. State and county medical societies throughout the United States have promulgated plans for carrying instruction to the general public, and the bureau has endeavored to assist these organizations in these important movements. The demands that have been made for certain kinds of educational material have been greater than could be supplied, but plans have been laid and are now in process of execution whereby the bureau will be enabled in the future to meet such demands more satisfactorily.

EXHIBITS

Important work in the dissemination of public health information can be done through exhibits installed at the meetings of scientific and of lay organizations, at expositions and at other places where the public is reached in great numbers. It is intended that the bureau shall accumulate material of this kind as speedily as its facilities will permit.

Exhibits of pamphlets, posters and charts from this bureau, the Council on Medical Education and Hospitals, and the Bureau of Investigation were made during the year as follows: At the annual meeting of the Superintendents' Section of the National Education Association in Chicago; at the National Congress of Parent-Teachers' Association in St. Paul; at the Minneapolis Health Exhibition in Minneapolis; at the annual session of the American Medical Association in Chicago; at the annual meeting of the American Hospital Association in Buffalo, and at the annual meeting of the American Dental Association in Dallas. Material has been provided also for exhibits under the auspices of county medical societies and other organizations.

PRINTED MATERIAL

The use of printed matter for the education of the public is constantly increasing. The pamphlets and leaflets of the American Medical Association issued under the direction of the Bureau of Health and Public Instruction were distributed during the year 1924 to the number of 323,182, which represents an increase of 35.4 per cent. over the distribution in 1923. New pamphlets have been made available as reprints from HYGEIA to the number of sixteen, all but four of which were printed in 1924. Others will be added as the demand may be made apparent for them, and some of the pamphlets that have been circulated in the past will be replaced by new ones, most of which will first be published in HYGEIA.

RADIO BROADCASTING

Broadcasting of readings from HYGEIA was continued monthly during the year from Station KYW, Chicago. Arrangements have been made through the secretaries of county medical societies in eight of the largest cities for similar broadcasting through radio stations in these cities.

PERIODIC HEALTH EXAMINATIONS

Continued effort has been made to promote periodic health examinations by practicing physicians. There has been a steady growth of interest in this movement, as has been shown by the increasing demand for examination forms and for copies of the original report prepared by the Council on Health and Public Instruction. This demand has come almost wholly from individual physicians and not from county medical societies. Comparatively few of these societies have taken up this subject in the manner suggested in the original resolutions passed by the House of Delegates at St. Louis. Some county societies, however, have done splendid work in this direction, and have succeeded in arousing a very active interest among their own members, which has naturally extended to the public whom they serve. The examination forms that have been printed by the Association and distributed through this bureau have not been altogether satisfactory to some county societies, nor to some individual physicians. This form was not expected to be universally received as altogether acceptable, but was issued with the hope and expectation that it would meet the needs of the average physician who might be called on by his clientele to make periodic examinations. The original report, in the nature of a very brief manual on periodic examinations, has met with a rather large distribution, more than 15,000 having been distributed during the year 1924. It has been supplanted by a larger manual prepared under the direction of a committee consisting of Drs. Isaac Abt, Joseph A. Capps, Charles E. Elliott, Haven Emerson, Joseph L. Miller, Alfred E. Shipley, Alec N. Thompson and Anna Mann Richardson, for whose work most grateful acknowledgment is hereby made. It is hoped that this larger manual will prove to be helpful to the physicians of the country.

HEALTH EDUCATION

The activities of the joint committee on health problems and education, representing the American Medical Association and the National Education Association, have been continued. The most recent and extensive report of this committee is entitled Health Education—A Program for Public Schools and Teacher Training Institutes. At the recent meeting of the joint committee at Cincinnati, additional work of importance was planned, including the publication of two reports, one on Ventilation and Heating, and one on the Conservation of Vision. It is proposed that the bureau shall continue as vigorously as possible its cooperative work with the National Education Association.

COOPERATION WITH COUNTY AND STATE MEDICAL SOCIETIES

While this bureau has given such aid as it could to the plans of county medical societies and of state medical associations in connection with their own activities for the proper instruction of the public, it is hoped that in the future considerably more aid may be rendered to these organizations. The bureau proposes to extend its activities as speedily as possible and to continue this cooperation by:

(*a*) Securing and exchanging information as to what various agencies are doing.

(*b*) Encouraging other medical societies to engage in this propaganda.

(*c*) Arranging, when possible, for national conferences of representatives of medical societies engaged in health activities.

(*d*) Aiding county societies and other organizations by providing for the supply by sale or rental of bulletins and abstracts for public addresses on health topics.

(*e*) Providing in a similar manner illustrative material, charts, posters and lantern slides.

(*f*) Securing and disseminating information about usable moving picture films on hygiene and allied subjects.

One session of the Annual Congress on Medical Education, Medical Licensure, Public Health and Hospitals was devoted to a program arranged by the Bureau of Health and Public Instruction on the general topic, The Medical and Health Education of the Public.

THE BUREAU OF LEGAL MEDICINE AND LEGISLATION

NATIONAL PROHIBITION ACTS

The matter of the medicinal use of alcohol came before the Board of Trustees under a resolution adopted by the House of Delegates in 1924, as follows:

Resolved, That the House of Delegates of the American Medical Association expresses its disapproval of those portions of the National

Prohibition Acts which interfere with the proper relation between the physician and his patient in prescribing alcohol medicinally; be it further

Resolved, That the House of Delegates of the American Medical Association instruct the Board of Trustees to use its best endeavor to have repealed such sections of the National Prohibition Acts as are in conflict with the above resolution and also use their best endeavor to have the Commissioner of Internal Revenue and the Prohibition Commissioner issue revised instruction on the use of the prescribing of alcoholic liquors for medicinal purposes by physicians.

To carry the foregoing resolution into effect, Dr. Woodward drafted a bill, and the Board of Trustees approved it and authorized its introduction into Congress. A canvass of the situation showed that there was no likelihood—it might be said, no possibility—of the passage of the proposed legislation during the then current short session of Congress. Action was suspended, therefore, until a more opportune time, in the belief that any effort to force legislation not only would be unsuccessful, but would react against future efforts.

NARCOTIC LAWS

Ban on Heroin.—Feb. 18, 1924, a bill was introduced into Congress to prohibit the importation of crude opium for the manufacture of heroin. The policy of the Association with respect to this matter had been defined by the House of Delegates at the New Orleans session, 1920, in a resolution approving a report of the committee on the narcotic drug situation, in which the following recommendation was made:

That heroin be eliminated from all medicinal preparations, and that it should not be administered, prescribed or dispensed; and that the importation, manufacture and sale of heroin should be prohibited in the United States.

In furtherance of this policy, the Board gave active support to this bill. It became a law, June 7, 1924.

Narcotic Survey.—Last June the House of Delegates recommended that a narcotic survey of the United States be made by the United States Public Health Service. The Surgeon General has informed the Board of Trustees, however, that it is impracticable just now to enlarge the narcotic program of the service.

Harrison Narcotic Act.—Efforts to procure the restoration to a peace basis of the war tax imposed under the Harrison Narcotic Act were begun by the Council on Health and Public Instruction as far back as May, 1921. After the creation of the Bureau of Legal Medicine and Legislation, in 1922, they were diligently continued up to the time of the enactment of the Revenue Act of 1924, through which it was hoped to procure relief. Nevertheless, the Revenue Act of 1924 was passed without providing the desired relief. The opposition came, apparently, from the Treasury Department and reached a climax in the recommendation that Congress increase, by a half million dollars a year, the appropriation for the enforcement of the narcotic law, so as to use up the revenue derived from the Harrison Narcotic Act. That recommendation was approved by Congress. The obvious effect is to confuse one of the chief arguments against the continuance of the war tax, namely, that the government is deriving revenue from an occupation tax on the medical profession not paralleled by any similar tax on any other profession. The facts that the personnel of Congress remained unchanged, that no general revision of the Revenue Act was under consideration, and that the last was a "short" session, combined to make it impossible to secure any reduction of the tax imposed on physicians under the Harrison act.

VETERANS' BUREAU

Training of Chiropractors.—The annual report of the Veterans' Bureau for 1923-1924 showed seventy-one veterans in process of manufacture into chiropractors. The World War Veterans' Act, 1924, however, provides that no vocational training shall be granted or continued to any person after June 30, 1926. The waste of government funds for chiropractic training may be expected, therefore, gradually to diminish, and to terminate on the date named.

State Medicine in the Veterans' Bureau.—The World War Veterans' Act, 1924, section 201, paragraph 10, authorizes the director of the Veterans' Bureau "so far as he shall find the existing government facilities permit, to furnish hospitalization and necessary traveling expenses to veterans of any war, military occupation, or military expedition since 1897, not dishonorably discharged, without regard to the nature or origin of their disabilities: *Provided*, That preference to admission to any government hospital for hospitalization under the provisions of this subdivision shall be given to those veterans who are financially unable to pay for hospitalization and their necessary traveling expenses."

The medical profession yields to no other body in its desire to see every veteran receive just reward for service rendered during the war. It gladly leaves to Congress the determination of the measure of that reward. The privileges conferred by this legislation are in the nature of such a reward. They are not conferred as a recompense for damage resulting from military or naval service, for they are available for injuries and diseases of all kinds that have not resulted from such service. Neither are they conferred to relieve distress, for equal privileges are granted to the rich and to the poor alike. How illogical it is to make the measure of this reward proportionate, not to the nature and extent of service rendered, but to the extent to which the recipient may chance to suffer from illness and injury altogether independent of his service, it is not necessary to discuss.

Why the government should enter into competition through subsidized physicians and hospitals with physicians and hospitals that are not subsidized, and that depend for their very existence on the patronage they receive from the sick and injured is not apparent. It has not yet authorized hungry, cold and inadequately clothed veterans to draw their supplies from Army and Navy commissary departments, nor has it authorized veterans who are inadequately housed to take up their dwellings on military and naval reservations. Protection from hunger, cold and exposure are as necessary to health and happiness as is medical and hospital care in time of illness and injury; yet the government has not entered into subsidized competition with the grocer, the coal man, the dealer in men's furnishings and the landlord.

The situation may almost be stigmatized as communistic medicine in its most militant form, endeavoring to edge its way into American life under the cloak of patriotism. It merits the most careful consideration of the House of Delegates.

FEDERAL INCOME TAX

Efforts were made to obtain relief through the Revenue Act of 1924 from the ruling of the Commissioner of Internal Revenue denying the professional character of traveling expenses incurred in attending meetings of medical organizations and of the expenses of graduate study. They were unsuccessful. Pending amendatory legislation, redress lies only through the Board of Tax Appeals and the courts. Unfortunately, however, most of the physicians who occasionally complain to the Association of the injustice of the Commissioner's ruling have been unwilling to become parties to test cases to try out the issue, and an appeal cannot be taken in a hypothetic case.

MEDICAL DEFENSE

The House of Delegates last June adopted the following resolution:

WHEREAS, It is extremely important that constituent state societies be kept in touch with decisions involving cases of alleged malpractice; be it

Resolved, That the Bureau of Legal Medicine and Legislation of the American Medical Association be asked to make and furnish a copy of these decisions to the office of constituent state societies for use by their attorneys.

The decisions named are available in the published court reports, but the cost of manifolding and distributing copies of them would be considerable. Moreover, abstracts of them are now published in the Medicolegal Notes of THE JOURNAL. It has seemed impracticable, therefore, to undertake the work called for by the resolution without drawing unduly on the resources of the Association.

MEDICAL PRACTICE ACTS

Since the last meeting of the House, the usual efforts have been made by the various groups of sectarian healers to enlarge the breadth of their activities and to establish themselves in new fields. They have been generally unsuccessful. On the other hand, unfortunately, efforts to strengthen our medical practice acts have been met with but little better success. As this report goes to press some important legislation in both of these fields is still pending in the legislatures remaining in session.

The Bureau of Legal Medicine and Legislation has had a great amount of correspondence with state associations and many interviews with their representatives regarding legislation of this character. General policies have been discussed, methods of procedure have been pointed out, drafts of proposed and of pending bills have been analyzed and criticized from a legal standpoint, and practical services rendered in connection with such legislation and with the enforcement of medical practice acts now in force. It is hoped that such efforts have proved helpful to the state associations in proportion to the time and thought devoted to the problems submitted. The results of such efforts are not always apparent on the face of the advice given.

Model Medical Practice Act.—The drafting of a model medical practice act has been discussed by the Association since 1908. Some work has been done in the past and is still being done toward the desired end. To draft such a bill would be a comparatively simple matter if no bill within this field had ever been enacted. Now, however, many laws must be studied in the light of a multiplicity of court decisions interpreting them, if the draftsman would avoid the pitfalls of his predecessors. It is hoped, however, that the work that is being done will result within reasonable time in something tangible for consideration by our state associations.

PROTECTION OF MEDICAL RESEARCH

The Society of Friends of Medical Progress, Inc., which received the approval of the House of Delegates in June last, has been reorganized as the American Association for Medical Progress, Inc. The purposes and plans of the organization have not been altered. It may be well, in order to make the record clear, for the House of Delegates to adopt a resolution endorsing the American Association for Medical Progress, Inc., under that name.

LYE LEGISLATION

The Bureau of Legal Medicine and Legislation has cooperated constantly with the Committee on Lye Legislation in the efforts authorized by the Association to procure the enactment of laws requiring proper labeling of household package of caustic lye and other corrosive substances. Since our last report, laws to accomplish that end have been enacted in Louisiana, Oregon, South Carolina and Vermont. The federal lye bills were not reported out of committee, and lapsed with the adjournment of Congress, March 4, last.

COSMETICS, HAIR DYES AND DYED FURS

In June last, the House of Delegates adopted a resolution, the gist of which is as follows:

Resolved, That the Section on Dermatology and Syphilology, through its regularly appointed Executive Committee, urgently recommend to the favorable attention of the American Medical Association (1) that they foster legislation placing cosmetic preparations under the Food and Drugs Act, and especially requiring the placing of the names of all poisonous ingredients on the labels; (2) that they foster legislation prohibiting the use of the most harmful types of ingredients in cosmetics; (3) that they foster legislation to prohibit the use of paraphenylendiamin as a dye for hair and fur; and that the American Medical Association urge laws with criminal liability to enforce the recognition of these demands.

To establish the framework for the proposed legislation, the chairman of the Section on Dermatology and Syphilology, at the request of the Board of Trustees, has appointed a technical committee to cooperate with the Bureau of Legal Medicine and Legislation in its activities under the foregoing resolution. It would be idle to undertake to procure the enactment of such legislation without evidence to show the nature and extent of the danger to be removed and without knowledge of existing laws that might possibly be applied to effect that end.

REORGANIZATION OF FEDERAL HEALTH ACTIVITIES

The long continued labors of the Congressional Joint Committee on the Reorganization of the Executive Departments culminated, June 3, 1924, in the introduction of bills into the Senate and House of Representatives, each entitled "A Bill to Provide for the Reorganization and More Effective Coordination of the Executive Branch of the Government to Create the Department of Education and Relief and for Other Purposes." In some fields of executive activity, something in the nature of reorganization was proposed, but so far as health activities are concerned, the bill seemed likely to destroy rather than to build up. Protests were made through the editorial columns of THE JOURNAL and through our constituent associations. In the end, Congress adjourned without having acted on this measure.

MISCELLANEOUS LEGISLATION

Our constituent associations are reminded of the availability of the Bureau of Legal Medicine and Legislation to help them in their legislative and legal problems. Some associations already submit their more important problems for consideration and advice in advance of the convening of their state legislatures. This permits more deliberate study of them than is possible when they come in during the legislative season. Constituent associations are urged to file with the bureau copies of bills and reports submitted to the legislature, and of laws enacted, so that they may be used in studying similar legislation as it arises in other states.

With a view to laying a foundation for the future work, the Bureau of Legal Medicine and Legislation is making an effort to obtain complete court records of court cases of special interest to the medical profession. In such work, there has been every evidence of willingness on the part of the state and county associations and of individual members of such associations to cooperate. Such records on file in Chicago will be available for all state associations and all members. The board urges continued cooperation in this work.

PROPOSED AMENDMENTS TO THE BY-LAWS

The time of the regular meetings of the Board of Trustees is fixed in the By-Laws for the first Friday in the month of February of each year, and immediately after the Annual Session of the House of Delegates. The meeting of the Board in February is the meeting at which budgets are adopted and plans made for carrying on the business of the Association for the current year. It is necessary that complete financial statements for the preceding fiscal year shall be in the hands of the Board of Trustees at this February meeting. It is sometimes difficult to secure all the necessary financial reports on which budgets for the year must be based in time for them to be thoroughly considered by the finance committee before the first Friday in February. In order that more time may be given for the proper consideration of financial reports for the preceding year before budgets for the current fiscal year are approved, the Board of Trustees recommends that Section I, Chapter 6, of the By-Laws be amended by substituting "the third Friday in the month of February of each year" for "the first Friday in the month of February of each year," so that the regular annual meeting of the Board may in the future be held on the third Friday of February.

It is also recommended that Section I, Chapter 6, of the By-Laws be so amended as to provide for the election of an executive committee of the Board of Trustees rather than for the appointment of such committee by the chairman of the Board.

McCORMACK MEMORIAL TABLET

In compliance with the instructions received from the House of Delegates, the Board of Trustees has installed in the Assembly Room of the Association's building, in Chicago, a bronze tablet as a memorial to Dr. J. N. McCormack. This tablet bears the following inscription:

TO
J. N. McCORMACK
WHO SERVED AMERICAN MEDICINE
AND THE AMERICAN MEDICAL ASSOCIATION
WITH DISTINGUISHED ABILITY AND FINE FIDELITY
THIS MEMORIAL TABLET
IS ERECTED

OFFICIAL DELEGATES FROM THE BRITISH MEDICAL ASSOCIATION TO THE AMERICAN MEDICAL ASSOCIATION

It is with very great pleasure that the Board reports to the House of Delegates the appointment of delegates from the British Medical Association to the annual session of the American Medical Association. We are sure that the House of Delegates and the entire membership of the American Medical Association will join with the Board of Trustees in extending a hearty welcome to these representatives of the organization in England, which has done so much to uphold the traditions of the medical profession in its own country and throughout the world.

On receipt of an invitation submitted through Dr. Alfred Cox, medical secretary of the British Medical Association, the Board of Trustees has authorized the President to appoint delegates to represent this Association at the annual meeting of the British Medical Association, to be held at Bath, England, in July. It is confidently believed that the interchange of official delegates between these two great scientific bodies will go far to strengthen the bonds of professional good will and to advance the cause of scientific medicine, which is the outstanding purpose of each of the two associations.

OFFICIAL DELEGATE FROM THE CANADIAN MEDICAL ASSOCIATION

It is also very pleasing to the Board of Trustees to report to the House of Delegates that the American Medical Association is to be favored again this year with the presence of an official delegate from the Canadian Medical Association in the person of its secretary, Dr. T. C. Routley of Toronto.

The American Medical Association is to be represented by its secretary as a delegate at the annual meeting of the Canadian Association, to be held in Winnipeg in June, 1925.

The Secretary of the Association has been authorized to extend to all Fellows of the Canadian Medical Association a very cordial invitation to attend this Annual Session, and the invitation has been properly forwarded.

APPROPRIATIONS FOR RESEARCH—SURVEY OF MEDICAL EDUCATION—EXTENSION OF HOSPITAL SERVICE

The Board of Trustees has for a number of years been making appropriations for research. These appropriations are expended under the direction of the Committee on Therapeutic Research, a subcommittee of the Council on Pharmacy and Chemistry, and a Committee on Scientific Research. The reports of these two committees are made a part of the report of the Board.

An appropriation of $3,000 was made at the February meeting of the Board for the purpose of a cooperative survey of medical education in the United States, to be undertaken jointly by the medical schools of the country, the Council on Medical Education and Hospitals of the American Medical Association, the Association of American Medical Colleges, and other organizations and institutions interested in the many problems of medical education which are presenting themselves and demanding careful study. This survey will be made in a very thorough manner, and will be continued over as long a period as may be necessary to secure all the facts that should be accumulated by such an enterprise.

The Board also continued the annual appropriation which has been made for several years for the benefit of the Hospital Library Service.

COMMITTEE TO COOPERATE WITH BUREAU OF INDIAN AFFAIRS

In compliance with the terms of the resolution adopted by the House of Delegates at the Chicago Session, the Board of Trustees appointed the following committee to cooperate with the Bureau of Indian Affairs and the Department of the Interior in the work undertaken by that bureau to reduce the prevalence of trachoma among the Indian tribes: W. H. Wilder, Chicago; Arnold Knapp, New York, and William C. Posey, Philadelphia.

RESOLUTIONS ON OCCASIONAL JOINT MEETINGS WITH THE CANADIAN MEDICAL ASSOCIATION

The resolutions introduced at the Chicago Session by Dr. George F. Keiper, delegate from Indiana, proposed occasional joint meetings of the American Medical Association and the Canadian Medical Association, the first to be held within five years, and that arrangements for such meetings should be entrusted to the Board of Trustees, which was directed to report at this annual session. The Constitution of the American Medical Association provides for the holding of meetings at any place in the United States, and makes no provision for meetings outside this country. To hold joint meetings with the medical association of any other country would necessitate changes in the articles of incorporation and in the Constitution and By-Laws of the Association. In view of legal problems which might arise as the result of holding meetings outside the United States, the Board of Trustees respectfully recommends that the resolutions above referred to be not adopted.

N. S. DAVIS MEMORIAL FUND

The N. S. Davis Memorial Fund has slowly accumulated, until there is now in hand the sum of $4,581.13. This fund is not large enough to accumulate rapidly, and it will therefore be many years before it can grow into a fund large enough to provide a memorial of a nature that would be altogether in keeping with the invaluable service rendered to the Association and to the medical profession by him in whose honor it was established. The Board of Trustees believes, however, that there should be no further delay in installing in the building of the Association some memorial which would better reflect the appreciation of the organization for the devoted service rendered by Dr. Davis. The President has, therefore, been requested to confer with members of the Davis family and to prepare plans for a fitting memorial. The Board of Trustees asks the approval of the House of Delegates for its plans in this matter.

THE SCIENTIFIC EXHIBIT

In the last few years the Scientific Exhibit has become one of the important features of the annual session. The number of applicants for space has increased so rapidly that the Committee on Scientific Exhibit is in position to make selections, which insures that the Exhibit, as a whole, will be of an exceedingly high order. The Scientific Exhibit at Chicago was notable for the splendid character of the material shown and for the great interest manifested by visiting physicians. Every day the spacious aisles were crowded with spectators who found this a place for real messages in medical advances; and the medical advances demonstrated anew the spirit of research of American physicians.

At Chicago a distinct departure from preceding exhibits was the creation of special committees to demonstrate certain *practical* applications (not *new* researches) of pathology and medicine. Because there was felt to be a need for such demonstration, the Board of Trustees appropriated $1,000 to cover the expenses; such exhibits, of course, were not open to awards. The Committee on Morbid Anatomy demonstrated fresh material received daily from Chicago hospitals

and the Bureau of Animal Industry. This demonstration aroused great interest and was daily attended by large numbers of physicians. Likewise, the Committee on Cardiology found ready response to the exhibit on the pathology of the heart and the clinical interpretation of the various instruments used in heart study.

The Motion Picture Theater, which is part of the Department of Scientific Exhibit, operated continuously during session hours. The attendance averaged 800, and so popular was this feature that at times many had to be turned away. One half of the speakers on this program are invited to participate, nominations being made by the section secretaries; this provides for representation of all fields of medicine. The other half of the program is made up from those who voluntarily apply for places. Thus the theater has become an outstanding factor of the annual meeting for education in the diagnosis and management of disease.

The commendable cooperation of the section secretaries with the Committee on Scientific Exhibit has made possible attractive features in both the Scientific Exhibit and the Motion Picture Theater; it is a policy which will be continued to the end that the sections will find the Scientific Exhibit a necessary adjunct for proper illustration of papers.

Graduate Extension Work

Diligent effort has been made to perfect the necessary organization for carrying out the plans for offering courses of clinical instruction to members of county societies, as proposed to this house at the last annual session. It has not been possible, however, to secure instructors of the type desired; moreover, prospective cost of the enterprise, conducted in the manner that will yield desired results, is larger than the amount of money that, in our judgment, can be safely appropriated for the purpose at this time. The plans for graduate extension work are therefore held in abeyance, with the hope that at some time in the reasonably near future they may be put into effect. The Board of Trustees has in no manner changed its position with respect to the importance of this undertaking nor as to the desirability of carrying it out.

Several state medical associations have already initiated activities of this nature. It may be that this particular work of carrying clinical instruction to members of county societies is more the function of the state association than of the national organization. However that may be, those state associations which have already initiated such programs are to be highly commended for their enterprise as well as for their evident purpose to make constructive helpful contribution for the professional benefit of their members generally. It is hoped that a way will soon be found by which the American Medical Association can, by supplementing the effort of its constituent associations, become actively helpful in providing clinical instruction for its members who cannot avail themselves of the facilities offered in medical centers far removed from their homes.

Donation for Research

The Board has received, and has officially accepted, a donation of $1,140 from Dr. R. O. Raymond, Flagstaff, Ariz. In making this gift, Dr. Raymond made no conditions other than that the money should be used for scientific research in accordance with the best judgment of the Board of Trustees. He has suggested that the name of Charles A. Brant be associated with the gift, which has therefore been designated the Charles A. Brant Fund.

Elections

The election of members for the Council on Pharmacy and Chemistry, for the editorial boards of the several special journals, and for standing committees resulted as follows:

Council on Pharmacy and Chemistry.—Drs. G. W. McCoy, F. G. Novy and George H. Simmons were elected to succeed themselves; Dr. Morris Fishbein, Editor of The Journal, was elected to serve as the seventeenth member.

Editors of Special Journals.—Drs. George Dock of Pasadena, W. A. Pusey of Chicago, Dean Lewis of Chicago, E. W. Taylor of Boston and Oscar M. Schloss of New York were reelected on the editorial boards of the Archives of Internal Medicine, Archives of Dermatology and Syphilology, Archives of Surgery, Archives of Neurology and Psychiatry and the American Journal of Diseases of Children, respectively.

Committee on Protection of Medical Research.—Dr. Simon Flexner of New York was reelected.

Committee on Scientific Research.—Dr. Martin H. Fischer of Cincinnati was elected to succeed Dr. G. N. Stewart.

Foot and Mouth Disease

The following resolutions are presented for the consideration of the House of Delegates, at the request of Dr. R. R. Ferguson, secretary of the American Medical Milk Commissions, and with the approval of this Board:

Whereas, An epidemic of foot and mouth disease occurred in California in 1924, resulting in the slaughter of more than 108,000 animals, at a cost to the state of California, the United States government and the owners of the flocks and herds destroyed of approximately $5,000,000; and

Whereas, This was the seventh epidemic of foot and mouth disease recorded in the United States; and

Whereas, The danger attendant on an epidemic of the disease in this country makes the destruction of infected flocks and herds the only safte method to pursue and prevents a systematic study of the nature of the disease; therefore be it

Resolved, That the American Medical Association join with the American Association of Medical Milk Commissions in an effort to have the Department of Agriculture, through proper sources, appoint a commission to study foot and mouth disease at its source, either in South America or in Europe, where it is always present, with a view of discovering some more effective and economic means of combating the disease; and be it further

Resolved, That a copy of these resolutions be sent to the Department of Agriculture, together with resolutions of a similar nature from the American Association of Medical Milk Commissions, the American Veterinary Association and other organizations interested in this important subject.

The Status of the Association's Business Affairs

The constant expansion in the activities of the councils, bureaus and departments of the American Medical Association and the growth and improvement of its scientific publications, together with the necessary additions of physical equipment and the required increase in personnel, necessitated the enlargement of its plant in Chicago. The building owned by the Association, which houses its offices and its mechanical plant, has been doubled in size. This means, of course, a large increase in maintenance costs of all kinds. Whereas a little more than a year ago only two elevators were needed, four are now constantly in use; the cost of lighting and heating has increased in proportion to the enlargement of the building; the increased value of the building and equipment have necessitated additional insurance. The equipment of the printing plant has been added to in keeping with the policy of the Association to maintain a first class printing department. The work of the various councils and bureaus has constantly expanded, necessitating an enlarged payroll and salary list. The publication of a journal for the lay public, as was expected, has required a very considerable annual outlay. Special publications of the Association, which represent a distinct service for the benefit of the medical profession and which cannot well be rendered by any other agency, the extension of library service, the enlargement of the Chemical Laboratory and the development of its work, have all necessitated increased expenditures. At the last session of Congress a new postal rate law was enacted, under the provisions of which the cost of mailing The Journal alone will amount to approximately $8,800 annually. Final disposition of the question of postal rates has not yet been made. A committee of Congress is studying all the problems involved, and will submit a report at the next session which may call for further changes in rates under which the mailing cost of the Association's publications will be considerably enhanced. There will also accrue increased mailing costs on account of other publications of the Association, as well as in some other classes of postal matter. During the current year a new cylinder press, already contracted for, will be installed, requiring an outlay of approximately $54,000. Old machinery and equipment will have to be replaced with new as necessity demands.

The income of the Association is principally secured from subscriptions, Fellowship dues, and advertising receipts. It has been the policy of the Board of Trustees and the administrative officers of the Association to maintain all its products on the highest possible plane of excellence. Economies have been effected whenever and wherever possible, provided no hurt would result to the quality of products. Liberal appropriations have been made for the use of the councils and bureaus in carrying out the helpful work which they have undertaken in the interest of the profession and the public.

It has been the policy of the Board of Trustees also to maintain subscription prices of the Association's publications at the lowest figure compatible with the production of meritorious periodicals. A year ago, in the face of increasing costs of operation and expanding activities, the subscription price of THE JOURNAL was reduced from $6 to $5 a year. An examination of the financial statements, which are made addenda to this report, will reveal that the net gain from all sources for the year 1924 is very much smaller than for a number of years. As a matter of fact, except for interest received on money permanently invested in fixed surplus funds and approximately $3,000 on miscellaneous accounts, there was no net income.

The surplus and reserve funds of the Association have been accumulated and maintained in an amount believed to be necessary for financial safety. There is no desire on the part of the officers or members of the Association that its activities shall result in the accumulation of money. The Board of Trustees, mindful of this fact, has earnestly endeavored to use all income above that necessary to meet basic expenses and to conduct the affairs of the Association in a businesslike manner in extending its services to its members and to the public. The scientific publications of the Association, its miscellaneous publications, and the work that it has done through its councils and bureaus all speak for themselves.

The Board of Trustees has not hesitated to cooperate financially or otherwise in any progressive movement which it believed to be for the advancement of scientific medicine or for the promotion of the welfare of the medical profession.

The American Medical Association is a sound concern, but it is not, as some seem to have conceived, an institution that has unlimited resources. The record which it has made in its service to humanity demands that its future activities shall be carried out on broad lines and altogether in keeping with the ideals that have governed its course heretofore. There can be no standing still. There must be expansion and intensification of effort, and the Association must at all times be in position to meet as promptly and as practically as possible all demands that can be rightfully made on it. This means, of course, that the Association must be insured an income that will provide for the maintenance of its legitimate activities, and that its reserve funds shall be large enough safely to meet any emergencies that may arise.

ADMINISTRATIVE PERSONNEL

The work of the administrative personnel of the Association has been characterized by a splendid spirit of loyalty and cooperation. The efficiency with which the Association's affairs have been administered has constituted a tribute to the genius and to the devoted service of Dr. George H. Simmons, who for twenty-five years was the chief executive officer of the Association, and to the faithfulness of the administrative personnel which he gathered about him.

W. T. WILLIAMSON,* Chairman.
J. H. WALSH, Secretary.
THOMAS MCDAVITT.
A. R. MITCHELL.
D. CHESTER BROWN.
OSCAR DOWLING.
CHARLES W. RICHARDSON.
J. H. J. UPHAM.
E. B. HECKEL.
W. A. PUSEY, W. D. HAGGARD, F. C. WARNSHUIS } Ex Officio.

* Died, March 2, 1925.

ADDENDA TO TRUSTEES' REPORT

TREASURER'S REPORT

Report of the Treasurer of the American Medical Association for the year ending December 31, 1924

ASSOCIATION RESERVE FUND

Reserve Fund as at December 31, 1923		$395,763.28
Transfer from General Office		94.00
Interest—Bonds	$16,979.00	
Interest—Uninvested Balance	440.21	
		$ 17,419.21
Reserve and Surplus as at December 31, 1924		$413,276.49

DAVIS MEMORIAL FUND

Bonds (at cost) as at December 31, 1923		$ 3,708.25
Bank Balance December 31, 1923	$ 679.81	
1924 Interest on Bonds	170.00	
1924 Interest on Bank Balance	23.07	
		$ 872.88
Total Fund as at December 31, 1924		$ 4,581.13

AUDITOR'S REPORT

CHICAGO, January 15, 1925.

To the Board of Trustees,
American Medical Association, Chicago, Illinois.
Dear Sirs:

In accordance with your instructions, we have audited the accounts of the American Medical Association, for the year ended December 31, 1924, and have prepared therefrom and append hereto the statements undermentioned:

Exhibit "A"—Balance Sheet as at December 31, 1924.
Exhibit "B"—Income Account for the year ended December 31, 1924.
Schedule "1"—Journal Operating Expenses.
Schedule "2"—Association and Miscellaneous Expenses.

We certify that the Balance Sheet and Income Account correctly present, in our opinion, the financial position of the Association as at December 31, 1924, and the result of its operations for the year ended on that date.

The cash and bank balances and securities owned have been verified by count or inspection or by certificates obtained from the depositories.

The charges to the Property and Equipment accounts during the year represent actual additions and improvements. The expenditure thereon, $190,180.45, has been made out of the floating assets of the Association. Depreciation written off during the year appears to be adequate.

During the course of the audit we made an exhaustive test of the various sources of income and verified the expenditures against properly approved vouchers on file. We have pleasure in reporting that the accounts are well and accurately maintained.

Yours truly,
PEAT, MARWICK, MITCHELL & CO.

EXHIBIT "A"

BALANCE SHEET AS AT DECEMBER 31, 1924

ASSETS:			
Property and Equipment at Cost, less Depreciation:			
Real Estate and Buildings			$ 695,551.29
Machinery			86,345.06
Type and Metal			6,932.15
Furniture and Equipment			48,320.53
Chemical Laboratory			3,417.39
Library			639.25
Total Property and Equipment			$ 841,205.67
Investments (at cost):			
U. S. Government Securities	$268,541.55		
Railroad and Municipal Bonds	118,926.50		$387,468.05
Cash held by Treasurer for Investment			$ 25,808.44
Cash in Bank and on Hand—General Account			23,612.01
Notes Receivable			2,242.86
Accounts Receivable:			
Advertising	$ 53,329.04		
Co-operative Medical Advertising Bureau	10,601.76		
Reprints	4,083.94		
Miscellaneous	13,257.25		$81,271.99
Inventories of Materials, Supplies and Work in Progress			79,448.52
Expenditure on Publications in Progress			76,635.42
Prepaid Expenses—Insurance, etc.			2,703.89
Total			$1,520,396.85

LIABILITIES:		
Accounts Payable:		
Co-operative Medical Advertising Bureau		$ 8,491.91
Miscellaneous		1,770.76
		$ 10,262.67
Subscriptions Paid in Advance		36,749.52
Advance Payments on Publications		90,591.44
Net Worth:		
Association Reserve Fund:		
Amount thereof as at December 31, 1923	$ 395,763.28	
Transferred to Capital Account	145,763.28	
	$ 250,000.00	
Capital Account:		
Amount thereof as at December 31, 1923	$965,983.99	
Transferred from Association Reserve Fund	145,763.28	
Net Income for the Year Ended December 31, 1924	21,045.95	1,132,793.22
Net Worth as at December 31, 1924		$1,382,793.22
Total		$1,520,396.85

EXHIBIT "B"

INCOME ACCOUNT

FOR THE YEAR ENDED DECEMBER 31, 1924

JOURNAL		
Gross Earnings:		
Fellowship Dues and Subscriptions		$ 418,737.18
Advertising		614,084.67
Jobbing		15,908.77
Reprints		8,477.58
Books		15,139.43
Insignia		5,695.52
Miscellaneous Sales		12,897.37
Interest		6,067.66
Miscellaneous		1,386.88
Gross Earnings from Journal		$1,098,395.06
Operating Expenses—Schedule "1"		859,861.95
Net Earnings from Journal		$ 238,533.11
Miscellaneous Income:		
Rents	$ 1,740.00	
Sundry Publications	4,656.41	
Co-operative Medical Advertising Bureau	1,420.15	7,816.56
Association Income:		
Income from Investments	$ 17,419.21	
Income from Other Sources	3,921.02	21,340.23
Gross Income		$ 267,689.90
Association Expenses—Schedule "2"	$127,681.32	
Miscellaneous Expenses—Schedule "2"	118,962.63	246,643.95
Net Income		$ 21,045.95

SCHEDULE "1"

JOURNAL OPERATING EXPENSES

FOR THE YEAR ENDED DECEMBER 31, 1924

Wages and Salaries			$386,230.41
Editorials, News and Reporting			11,750.60
Paper—Journal Stock			261,562.89
Paper—Miscellaneous			6,037.44
Electrotypes and Engravings			19,906.02
Binding			737.97
Ink			6,974.88
Postage—First Class			23,440.36
Postage—Second Class			41,475.15
Journal Commissions			6,633.08
Collection Commissions			2,109.60
Discounts			14,453.01
Express and Cartage			4,215.53
Exchange			2,519.05
Office Supplies			1,984.12
Telephone and Telegraph			2,242.93
Office Jobbing			8,671.23
Power and Light			5,748.96
Factory Supplies			10,238.99
Repairs and Renewals—Machinery			6,406.67
Miscellaneous Operating Expenses			20,245.66
			$843,584.55
Depreciation on Property and Equipment:			
Machinery	10%	$9,593.89	
Furniture and Equipment	10%	3,736.07	
Factory Equipment	10%	1,632.87	
Type	10%	334.77	
Metal	20%	979.80	16,277.40
Total Journal Operating Expenses			$859,861.95

SCHEDULE "2"

ASSOCIATION AND MISCELLANEOUS EXPENSES

FOR THE YEAR ENDED DECEMBER 31, 1924

Association Expenses:	
Association	$ 48,811.76
Health and Public Instruction	8,977.00
Pharmacy and Chemistry and Chemical Laboratory	25,754.03
Medical Education and Hospitals	27,832.30
Organization and Field Secretary	3,066.59
Therapeutic Research	1,025.85
Legal Medicine and Legislation	11,834.08
Laboratory Depreciation—10%	379.71
Total Association Expenses	$127,681.32
Miscellaneous Expenses:	
Insurance and Taxes	$ 16,108.74
Legal and Investigating	1,308.32
Building Expense	26,187.11
Sundry Publications	68,313.95
Library Depreciation—10%	71.03
Fuel	6,973.48
Total Miscellaneous Expenses	$118,962.63

RECORDS OF GRANTS BY THE COMMITTEE ON SCIENTIFIC RESEARCH OF THE AMERICAN MEDICAL ASSOCIATION, 1903-1924

This list gives the amount of the grants and the articles containing the results of the work aided by the grants. In some cases, grants were made to the director of a laboratory for use as he saw fit in aiding research; in most cases, however, the grants were made to individual workers, on application stating the problem to be investigated and why aid was needed. It is believed that all articles in the following list, without exception, contained an acknowledgment of the aid received from the American Medical Association. A complete file of the articles is on hand in the archives of the committee.

1. 1903. $100. Gustav F. Ruediger, Chicago. The production and nature of streptocolysin. J. A. M. A. **41**: 962, 1903.

2. 1903. $100. F. J. Otis and Newton Evans, Battle Creek, Mich. The morphology and biology of the parasite from a case of systemic blastomycosis. J. A. M. A. **41**: 1075, 1903.

3. 1904. $100. Gustav F. Ruediger, Chicago. The mechanism of streptococcus infection. J. A. M. A. **44**: 198, 1905.

4. 1904. $100. Leo Loeb, Philadelphia. The formation of the corpus luteum in guinea-pig. J. A. M. A. **46**: 416, 1906.

5. 1905. $100. Gustav F. Ruediger, Chicago. Further studies in streptococcus infections. J. A. M. A. **46**: 108, 1906.

6. 1905. $100. R. M. Pearce, Albany Medical College. H. C. Jackson and K. D. Blackfan. The action of certain drugs on the elimination of uric acid during a nitrogen-free diet. Albany M. Ann. **28**: 34, 1907.

7. 1906. $200. H. T. Ricketts, Chicago. A study of Rocky Mountain "spotted fever" (tick fever?) by means of animal inoculations. J. A. M. A. **47**: 33, 1906. The transmission of Rocky Mountain spotted fever through the bite of the wood tick (Dermacentor occidentalis). J. A. M. A. **47**: 358, 1906. Further observations on Rocky Mountain spotted fever and Dermacentor occidentalis. J. A. M. A. **47**: 1067, 1906.

8. 1906. $100. R. M. Pearce, Albany Medical College. L. K. Baldauf. An investigation of the nature of proteid-soap compounds and of the michrochemical staining of pure fats and lipoids by scharlach R and sudan III. J. A. M. A. **49**: 642, 1907.

9. 1906. $200. Gustav F. Ruediger, Chicago. Bacteria in scarlatinal and normal throats. J. A. M. A. **47**: 1171, 1906. Streptococci from scarlatinal and normal throats and from other sources. J. Infect. Dis. **3**: 755, 1906.

10. 1907. $100. R. M. Pearce, Albany Medical College. C. W. L. Hacker. Concerning the appearance of glycuronic acid in certain conditions of diminished oxidation. J. A. M. A. **50**: 252, 1908.

11. 1907. $100. H. C. Jackson, Albany, N. Y. H. C. Jackson and A. W. Elting. Clinical notes and physicochemical study of salt elimination in the urine of an individual with general edema of obscure origin. Arch. Int. Med. **2**: 201, 1908. H. C. Jackson and C. B. Hawn. Variations in the concentration of the blood as affecting the opsonic index. Arch. Int. Med. **9**: 55, 1912.

12. 1908. $200. R. M. Pearce, University and Bellevue Hospital Medical College, New York. H. F. Swift. A comparative study of serum diagnosis in syphilis. Arch. Int. Med. **4**: 376, 1909. H. F. Swift. The use of active and inactive serum in the complement deviation test for syphilis. Arch. Int. Med. **4**: 494, 1909.

13. 1908. $200. H. T. Ricketts, Chicago. Observations on the various means of transmission of Rocky Mountain spotted fever. J. Infect. Dis. **4**: 141, 1907.

14. 1908. $200. Isabella C. Herb, Chicago. Experimental parotitis. J. A. M. A. **51**: 668, 1908.

15. 1909. $50. H. T. Glenn. The comparative disinfective power of chinosol, carbolic acid and mercuric chlorid.

16. 1909. $200. H. T. Ricketts, Chicago. A micro-organism which apparently has a specific relationship to Rocky Mountain spotted fever, J. A. M. A. **52**: 379, 1909. Tr. Chicago Path. Soc. **7**: 254, 1907-1909.

17. 1909. $200. R. M. Pearce, University and Bellevue Hospital Medical College, New York. H. F. Swift. The effect of treatment on the Wassermann reaction. Arch. Int. Med. **6**: 626, 1910. H. F. Swift and W. C. Thro. A study of streptococci with the complement fixation and conglutination reactions. Arch. Int. Med. **7**: 24, 1911. MacRae and A. B. Eisenbrey and H. F. Swift. The use of pure lipoids and alcoholic extracts with active and inactive serum in the complement fixation tests for syphilis. Arch. Int. Med. **6**: 469, 1910.

18. 1909. $200. W. G. MacCallum and Carl Voegtlin, Baltimore. On the relation of tetany to the parthyroid glands and to calcium metabolism. J. Exper. Med. **11**: 118, 1909.

19. 1909. $200. Isabella C. Herb, Chicago. Experimental parotitis. Arch. Int. Med. **4**: 201, 1909.

20. 1909. $100. Gerald B. Webb. Colorado Springs, Colo. For investigation of immunity in tuberculosis. See Grant 22.

21. 1910. $200. R. M. Pearce, University and Bellevue Hospital Medical College, New York. H. T. Karsner and J. H. Austin. Studies in infarction: experimental bland infarction of the kidney and spleen. J. A. M. A. **57**: 951, 1911. H. T. Karsner and J. N. Nutt. The relation of the toxic dose of horse serum to the protective dose of atropin in anaphylaxis. J. A. M. A. **57**: 1023, 1911.

22. 1910. $100. Gerald B. Webb, Colorado Springs, Colo. Gerald B. Webb and W. Whitridge Williams. Immunity in tuberculosis; its production in monkeys and children. J. A. M. A. **57**: 1431, 1911.

23. 1910. $200. E. C. Rosenow, Chicago. Autolysis of pneumococci. J. Infect. Dis. **10**: 113, 1912.

24. 1911. $200. R. M. Pearce, University of Pennsylvania, Philadelphia. J. H. Musser, Jr. An experimental study of the changes in the blood following splenectomy. Arch. Int. Med. **9**: 592, 1912. J. H. Austin and A. B. Eisenbrey. The utilization of parenterally introduced serum. Arch. Int. Med. **10**: 305, 1912.

25. 1911. $200. Mary R. Lawson, Boston. The development of the tertian malarial parasite. Arch. Int. Med. **9**: 420, 1912.

26. 1911. $200. Karl K. Koessler, Chicago. See Grant 28.

27. 1912. $200. A. Sophian, New York. Prophylactic vaccination against meningitis. J. A. M. A. **59**: 527, 1912.

28. 1912. $200. Karl K. Koessler and Jessie M. Koessler. Specific antibodies in scarlet fever. J. Infect. Dis. **9**: 366, 1911.

29. 1913. $200. R. M. Pearce, University of Pennsylvania, Philadelphia. Philip F. Williams and Richard M. Pearce. Abderhalden's biological test for pregnancy. Surg., Gynec. & Obst., 1913, p. 411. J. H. Austin and O. H. P. Pepper, Philadelphia, Pa. Experimental observations on the coagulation of oxalated plasma, with a study of some cases of purpura. Arch. Int. Med. **11**: 305, 1913.

30. 1913. $450. William DeB. MacNider, University of North Carolina. On the difference in the effect of Grehant's anesthetic and of morphine-ether on the total output of urine and the composition of the urine in normal dogs. Proc. Soc. Exper. Biol. & Med. **10**: 95, 1913. A study of the action of various diuretics in uranium nephritis, with special reference to the part played by the anesthetic in determining the efficiency of the diuretic. J. Pharmacol. & Exper. Therap. **4**: 491, 1913. The effect of different anesthetics on the pathology of the kidney in acute uranium nephritis. J. M. Res. **28**: 403, 1913.

31. 1913. $250. Benjamin White and Oswald T. Avery, Brooklyn. Some immunity reactions of edestin. The biological reactions of the vegetable proteins. III. J. Infect. Dis. **13**: 103, 1913.

32. 1913. $200. F. P. Gay, Berkeley, Calif. Edith J. Claypole. Human streptotrichosis and its differentiation from tuberculosis. Arch. Int. Med. **14**: 104, 1914.

33. 1914. $400. William DeB. MacNider, University of North Carolina. The vascular response of the kidney in acute uranium nephritis—the influence of the vascular response of diuresis. J. Pharmacol. & Exper. Therap. **6**: 123, 1914. On the difference in the response of animals of different ages to a constant quantity of uranium nitrate. Proc. Soc. Exper. Biol. & Med. **11**: 159, 1914.

34. 1914. $200. Gerald B. Webb and George B. Gilbert, Colorado Springs, Colo. Immunity in tuberculosis. J. A. M. A. **63**: 1098, 1914. M. E. Staines, T. L. James and C. Rosenberg. Lymphocyte increase and altitude. Arch. Int. Med. **14**: 376, 1914. G. B. Webb, G. B. Gilbert and L. C. Havens. Blood platelets and tuberculosis. Arch. Int. Med. **14**: 743, 1914.

35. 1914. $250. Yandell Henderson and Alexander L. Prince, Yale University. The oxygen pulse and the systolic discharge. The systolic discharge and the pericardial volume. Am. J. Physiol. **35**: 106 and 116, 1914.

36. 1914. $200. E. R. LeCount and Kaethe Dewey, Chicago. Syphilitic leptomeningitis. J. Infect. Dis. **16**: 142, 1915.

37 and 41. 1919. $600. William DeB. MacNider, University of North Carolina. The inhibition of the toxicity of uranium nitrate by sodium carbonate, and the protection of the kidney acutely nephropathic from uranium from the toxic action of an anesthetic by sodium carbonate. J. Exper. Med. **23**: 171, 1916. On the occurrence and distribution of potassium in normal and nephropathic kidney cells. Proc. Soc. Exper. Biol. & Med. **13**: 10, 1915. A pathological study of the naturally acquired chronic nephropathy of the dog. J. M. Res. **34**: 177, 1916. A pathological and physiological study of the naturally nephropathic kidney of the dog, rendered acutely nephropathic by uranium or by an anesthetic. J. M. Res. **34**: 199, 1916.

38. 1913. $350. C. C. Bass and F. M. Johns, New Orleans. Pyorrhea dentalis and alveolaris. J. A. M. A. **64**: 553, 1915.

39. 1919. $1,000 ($400 still unpaid). E. O. Jordan, University of Chicago. For critical review of the literature on the influenza epidemics of 1918 and 1919, as requested by Dr. George H. Simmons and the committee. The completed work will be submitted next year.

40. 1919. $200. Roy L. Moodie, University of Illinois. New observations in paleopathology. Ann. M. History, 1918.

41. See Grant 37.

42. 1919. $200. M. S. Tongs, St. Louis. Hemolytic streptococci in the nose and throat. J. A. M. A. **73**: 1050, 1919. Ecto-enzymes of streptococci. J. A. M. A. **73**: 1277, 1919.

43. 1919. $200. E. E. Ecker, Cleveland. Canceled.

44. 1919. $200. H. Y. Barbour, Yale University. A. M. Hjort and J. T. Egan. Benzylcarbinol: a local anesthetic. J. Pharmacol. & Exper. Therap. **14**: 211, 1919. A. M. Hjort and C. E. Kaufmann. The local anesthetic properties of phenyl methyl carbinol. J. Pharmacol. & Exper. Therap. **15**: 129, 1920. A. M. Hjort and C. E. Kaufmann. The local anesthetic properties of benzyl carbinol. Proc. Soc. Exper. Biol. & Med. **17**: 79, 1920.

45. 1920. $400. G. C. Huber, Ann Arbor. For a study of nerve repair. The report of this work will probably appear in one of the volumes of the history of the World War.

46 and 50. 1920-1921. $400 and $450. Herbert M. Evans, University of California. Characteristic effects on growth, estrus and ovulation induced by the intraperitoneal administration of fresh anterior hypophysial substance. Proc. Nat. Acad. Sc. **8**: 38, 1922. The estrous cycle in the rat and its associated phenomena. Memoirs of University of California, **6**, 1922.

47. 1920. $100. E. R. LeCount, Rush Medical College, Chicago. Lester R. Dragstedt. Effect of Streptococcus hemolyticus infection on the reaction of the blood of rabbits. J. Infect. Dis. **27**: 452, 1920. Carl W. Apfelbach. Studies in traumatic fractures of the cranial bones. Arch. Surg. **14**: 434, 1922.

48. 1920. $200. H. T. Karsner and E. E. Ecker, Western Reserve University. Specificity of the desensitized state in serum anaphylaxis. J. Infect. Dis. **30**: 333, 1922.

49. 1920. $400. Henrietta A. Calhoun, University of Iowa. Effect of injection of nonspecific protein on diphtheria virulence tests in guinea-pigs. Am. J. Dis. Child. **21**: 107, 1921.

50. See Grant 46.

51. 1921. $300. Stanford University. Thomas Addis and D. R. Drury. The rate of urea excretion. V. The Effect of changes in blood urea concentration on the rate of urea excretion. J. Biol. Chem. **55**: 105, 1923. D. R. Drury. The rate of urea secretion. VI. The effect of very high blood urea concentrations on the rate of urea excretion. J. Biol. Chem. **55**: 113, 1923. Thomas Addis and D. R. Drury. The rate of urea excretion. VII. The effect of various other factors than blood urea concentration on the rate of urea excretion. J. Biol. Chem. **55**: 629, 1923. Thomas Addis and D. R. Drury. The rate of urea excretion. VIII. The effect of changes in urine volume on the rate of urea excretion. J. Biol. Chem. **55**: 639, 1923.

Pending. 52. 1921. $400. William H. Welker, University of Illinois, for study of chemistry of bacterial proteins. Work in progress. Nearly completed.

Pending. 53. 1921. $300. Frank P. Underhill, Yale University. E. G. Gross and F. P. Underhill. The metabolism of inorganic salts. I. The inorganic ion balance of the blood in parathyroid tetany. J. Biol. Chem. **54**: 105, 1922.

54. 1921. $350. Albert Keidel, Johns Hopkins Hospital. A. M. Chesney and J. E. Kemp. Spirochaeta pallida in cerebrospinal fluid in early stages of syphilis. J. A. M. A. **83**: 1725, 1924.

Pending. 55, 63, 70. 1922, 1923, 1924. $600. R. A. Spaeth, Johns Hopkins University, for study of influence of fatigue on infection. The work is completed and the results will be published in the *American Journal of Hygiene*.

56. 1922. $200. John W. Churchman, Cornell University Medical School. The mechanism of bacteriostasis. J. Exper. Med. **37**: 543, 1923.

Pending. 57 and 61. 1922 and 1923. $369.46. Yandell Henderson, Yale University, for purchase of kymograph. The result of work aided by this grant is in the course of publication.

58. 1922. $225. E. B. Krumbhaar, Philadelphia. J. C. Small and L. A. Julianelle. Biologic and serologic studies of Bacillus mucosus group. J. Infect. Dis. **32**: 456, 1923.

Pending. 59. 1922. $225. F. W. Mulsow, University of Iowa, for study of best medium for gonococcus. This work is completed and the results are in course of publication.

Pending. 60 and 71. 1922 and 1924. $800. H. M. Evans, University of California, for study of endocrine glands. Work in progress.

61. See Grant 57.

Pending. 62. 1923. $150. A. C. Ivy, University of Chicago, for study of influence of amino-acids and amins on gastric secretion. This work is completed and the results are in course of publication.

63. See Grant 55.

Pending. 64. 1923. $200. E. R. LeCount, Rush Medical College, for study of tuberculosis and mitral disease. Work in progress.

65. 1923. $300. L. E. Hines, St. Joseph's Hospital, Chicago. Intestinal flora in diarrhea. J. Infect. Dis., 1924.

Pending. 66. 1923. $250. H. G. Rowell, Columbia University, for nutrition studies in children. This work is completed and the results are in course of publication.

67 and 73. 1923 and 1924. $300. Joseph M. Scott and Charles E. Simon, Johns Hopkins University. Experimental measles. Am. J. Hyg. **4**: 559 and 725, 1924.

Pending. 68. 1924. $200. J. F. McClendon, University of Minnesota, for purchase of precision wave meter for study of electrical conductivity of cells. Work in progress.

Pending. 69. 1924. $400. Linda B. Lange, Johns Hopkins University, for study of diet in experimental tuberculosis. Work in progress.

70. See Grant 55.

71. See Grant 60.

Pending. 72. 1924. $250. V. C. Jacobson, Albany Medical College, to aid in study of implantation adenomas of pelvic organs. Work in progress.

73. See Grant 67.

Pending. 74. 1924. $300. Thomas Addis, Stanford University, to aid in the study of compensatory renal hypertrophy. Work in progress.

Pending. 75. 1924. $200. Victor Burke, State College of Washington, to aid in the study of dye treatment of infections. Work in progress.

REPORT OF THE JUDICIAL COUNCIL

Dr. M. L. Harris, Illinois, Chairman, presented the report of the Judicial Council, which was referred to the Reference Committee on Reports of Officers:

To the Members of the House of Delegates of the American Medical Association:

The Judicial Council held its regular annual meeting in Chicago, Nov. 17, 1924, at which time it disposed of such business as had been submitted. In the interim all matters which have been presented to the Council of such nature as could be satisfactorily handled through correspondence have received prompt attention, while those which could not be so attended to are now under consideration by the Council and will be acted on in the regular manner.

A great many communications have been addressed to the Council during the year, but the volume of these has not been as great as for the two or three preceding years. The Council is disposed to see in this fact encouragement for believing that its consistent policy of trying to have all questions of a local nature concerning medical conduct and organizational affairs referred to and considered by the proper agencies of the societies of original jurisdiction is beginning to produce desired results. In the opinion of the Judicial Council, it is important that the county society and the state association deal originally with all questions of conduct, organization and discipline which concern their individual members or which concern these societies and associations as such. The Council, however, desires to reiterate its willingness to assist the constituent and component units of the American Medical Association and the individual members thereof in any way possible in handling such matters.

Patents and Perquisites

Section 5 of Article I, Chapter II of the Principles of Medical Ethics reads as follows:

> PATENTS AND PERQUISITES
>
> It is unprofessional to receive remuneration from patents for surgical instruments or medicines; to accept rebates on prescriptions or surgical appliances, or perquisites from attendants who aid in the care of patients.

Inquiries are constantly coming to the Council concerning the various questions involved in the issuance of patents to physicians. This whole subject is now being studied by the Council and a report will be made to the House of Delegates at the next annual session if, in the opinion of the Council, any amendment of the Principles of Medical Ethics is demanded in this connection.

Periodic Health Examinations by Lay Organizations

At the last annual session of the Association, held in Chicago, the Judicial Council presented to the House of Delegates a supplementary report dealing with the specific question: Shall the medical profession vend its products directly to the consumer or shall it sell them to a middleman or third party? This question was discussed in the report of the Council from the standpoint of the independence of the physician, the interest of the individual patient, the encouragement of medical progress, and from the standpoint of what is best for the public. The conclusion of the Council, which was endorsed and accepted by the House of Delegates, was to the effect that the proper person to make periodic examinations and to give advice relative thereto is the family physician, aided when necessary by local specialists; and that indirect medical service through a third party could not redound to the benefit either of the public or of the physician. In submitting that report to the House of Delegates, neither the Council as a whole nor any individual member of the Council was guided by any motive other than a desire to bring the questions considered in the report directly to the attention of the members of the American Medical Association and its duly elected delegates, in the hope that the best interests of the medical profession and of the public served by its members might be conserved. It was the purpose of the Council to discuss fundamental principles, and its supplementary report was offered on that basis. It was not the purpose of the Council to call into question the honesty or the sincerity of purpose of any person or group.

The Judicial Council desires to express again its firm conviction that the benefits of scientific medicine cannot be adequately delivered to the individual through the medium of a third party, and that the communication of results of physical examination and the general advice with which it should be associated should go directly from the individual physician to his patients. As was stated in the report of the Council submitted at the Chicago session, the relation between the patient and the physician is an individual matter, and anything that disturbs this relationship is detrimental to the best interests of the patient.

Supplementary Report

If the Council can find opportunity to give proper consideration to some pending matters, it will present a supplementary report to the House of Delegates during this session.

M. L. Harris, Chairman.
W. S. Thayer.
I. C. Chase.
J. N. Hall.
F. W. Cregor.
Olin West, Secretary ex officio.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION AND HOSPITALS

Dr. Arthur Dean Bevan, Illinois, Chairman, presented the report of the Council on Medical Education and Hospitals, which was referred to the Reference Committee on Reports of Officers:

To the Members of the House of Delegates of the American Medical Association:

The present report of the Council makes reference to (1) medical education; (2) present supply of physicians in the United States; (3) graduate medical education; (4) hospital service, and (5) miscellaneous items that have been referred to the Council for decision.

1. Medical Education

There are now eighty medical schools in the United States, one more than last year, the one added being the new medical school of the University of Rochester, N. Y. Eighty medical schools is the largest number in any of the civilized nations, and is one fourth of the world's supply. In 1904, this country had 160, which was more than half of the world's supply. The reduction was due mostly to mergers whereby in each of the many cities one invariably better college was formed by the union of two or more poorer institutions. At present sixty-three, or 78.7 per cent., of the medical schools are actually departments of universities, as compared with only thirty-six, or 22.5 per cent., in 1904. In 1906, about forty of the medical schools were without either laboratories or clinics, the instruction was didactic, and the faculties consisted of from one to five teachers each. Less than sixty of the 160 institutions possessed hospital facilities by which even a fair percentage of clinical instruction could be carried on. The remainder had neither teaching hospitals nor access to others where hospital patients could be used other than occasionally in amphitheater clinics. Less than half of the schools had outpatient departments or dispensaries wherein teaching clinics could be held with any regularity. Now, in contrast, thirty-four of the seventy medical schools teaching the clinical subjects have their own teaching hospitals, and thirty have access to other hospitals by which satisfactory clinics are being regularly held. Instead of the majority of medical schools being small, poorly equipped institutions with inadequate faculties and no developed curriculums, now sixty are well developed medical schools with adequate faculties, laboratories and hospitals, and ten others are well developed for the first two years of the medical

course. There are now about thirty medical schools, each of which has a group of buildings and a campus as large as or larger than those of the average university, and this number is increasing.

In 1904, less than thirty of the 160 medical schools required as much as a four year high school education for admission; now, in seventy-five of the eighty medical schools the minimum requirement is two years of college work. This requirement is not unreasonably high, but is merely a belated adoption in the United States of the standards long since required in other parts of the civilized world. In countries abroad the entrance requirement to medical schools is completion of the secondary school course, which, however, is equivalent to one and a half or two years of college work in the United States; and the graduate of the secondary schools of Europe are usually granted that amount of credit toward the baccalaureate degree in colleges of this country.

STUDENT ENROLMENT

The higher entrance requirements are not preventing students from entering on the study of medicine, and the total enrolments since 1919 have been increased at the rate of about 1,000 students a year. The enrolment in 1925 was approximately 18,368, the largest number enrolled since 1912. Instead of only 640 medical students enrolled in 1904 in medical schools whose basic requirements were two years or more of college work, in 1924 there were 17,358 students in these better institutions. The average *enrolment* in each college is now 230 students, as compared with only 174 in 1904. The *capacity* of each Class A college on the average at present is 317, and recent reports state that with certain additions or modifications this capacity can be further increased, if necessary, to 386.

MEDICAL SCHOOL GRADUATES

With the changes in medical education between 1904 and 1919, a reduction in the number of both students and graduates was expected. Readjustments under the newer conditions were rapidly made, however, so that both enrolments of students and the numbers of graduates are again rapidly on the increase. As shown in the accompanying chart, the

TABLE 1.—*Enrolments of Medical Students for Fourteen Years, Showing Variation in Numbers by Classes*

College Session	Freshmen	Sophomores	Juniors	Seniors	Totals
1911-1912	0,048	4,063	4,294	4,750	18,412
1912-1913	4,564	4,066	3,639	4,444	17,015
1913-1914	4,684	3,961	3,807	3,955	16,502
1914-1915	3,373	3,919	3,675	3,864	14,801
1915-1916	3,582	3,094	3,559	3,727	14,022
1916-1917	4,107	3,117	2,866	3,674	13,764
1917-1918	4,283	3,521	2,898	2,983	13,630
1918-1919*	3,104	3,587	3,272	2,967	12,930
1919-1920	4,234	2,837	3,464	3,263	13,798
1920-1921	4,825	3,588	2,637	3,416	14,466
1921-1922	5,412	4,219	3,355	2,649	15,635
1922-1923	5,162	4,615	3,861	3,322	16,960
1923-1924	5,160	4,441	4,330	3,797	17,728
1924-1925*	5,456	4,502	4,311	4,162	18,368

* Estimate.

The lowest ebb of the enrolment in the respective classes during the general reorganization of the medical schools is shown by the figures underscored by the solid line. The broken line is under the figures showing a temporary diminution due to the World War. The total number of students enrolled has steadily increased since 1919, and the present total is nearly equal to that of 1912.

increase in the number of graduates in the five years from 1922 to 1927[1] is about equal to the decrease in the fourteen years between 1908 and 1919. Here, again, instead of only thirty-six students graduating from the average medical college in 1904, this year the average will be about fifty, and it is estimated that the average will be further increased to approximately seventy-five by 1927. These increases in the numbers graduating, it must be recalled, represent those who have received a better foundation, both in general and in professional education.

1. The figures for 1925, 1926 and 1927 are estimated.

TABLE 2.—*Quantity vs. Quality*

	Two Years of College Work		High School or Less		
	Number	Per Cent.	Number	Per Cent.	Total
Medical Colleges:					
1904	2	1.3	158	98.7	160
1924	75	93.7	5	6.3	80
Students:					
1904	640	2.3	27,502	97.7	28,142
1919	12,552	91.7	500	3.8	12,930
1924	17,358	98.0	370	2.0	17,728
Graduates:					
1904	178	3.1	5,569	96.9	5,747
1922	2,347	92.8	182	7.2	2,529
1924	3,458	97.0	104	3.0	3,562

MEDICAL CURRICULUM

It was the great improvements, whereby more complete and satisfactory courses of instruction were being offered by medical schools, that created the later problem regarding the medical curriculum. Formerly, the importance of many subjects now included in the medical curriculum had not been recognized; but, as the value of such instruction became apparent, they were added to the curriculum. The result eventually was a badly crowded curriculum. Measures for readjustment and the proper correlation of courses are already in process, not only to eliminate duplication of courses, but also, if possible, to enable the student to get a satisfactory understanding of the essential facts in less time. This problem has not been unseen or ignored since the revision of the medical curriculum has been the main topic of discussion in conferences on medical education for the last four or five years. The fact that the curriculum needs revision, however, is a matter for congratulation, since between 1900 and 1910 there was in the majority of schools no curriculum to revise. A special commission was created in 1923, which is making a careful study of this problem.

LIMITATION OF ENROLMENTS

The reduction in the number of medical schools would have been serious had it not been for the greatly enlarged plants and the increased capacity of the institutions during the reorganization. Hence, the medical schools have been able to provide space for all qualified students, even with the unprecedented crowds of medical students seeking admission since the World War. The increased numbers made it necessary, however, for medical schools to limit the numbers of students enrolled in order to guarantee them efficient instruction. Most of the medical schools fixed for their limitations numbers of students larger than what they had enrolled up to that time. The limitation of the study body by a medical school had its usual psychologic effect in stimulating the desire of individual students to get in before the lists were closed. These barriers caused more or less difficulty, since the student had to apply to or even matriculate in several institutions in order to insure enrolment in a medical school of his choice. This duplication made the number of applicants appear to be larger than was actually the case. This led to the statement that "many students were turned away"; "more students were turned away than were previously enrolled," or other like announcements. These statements were widely published in the newspapers, and the situation was greatly exaggerated. Surveys by the Council during the last several years have invariably shown that vacancies were still found in Class A medical schools after the enrolments were completed. At no time has the utmost capacity in the Class A medical schools been reached.

INCREASING CAPACITY OF MEDICAL SCHOOLS

Although the present *enrolment* in all medical schools is given as 18,368, it was reported also that 1,355 vacancies still remain, which would make a total *capacity* of 19,923. In Class A medical schools alone this capacity is given as 19,000. The few hundred students, therefore, who enrolled in Class B and C colleges could have entered Class A medical schools if their qualifications were adequate. The Class A medical schools report that with additional teachers, enlarged laboratories, increased clinical material or the subdivision of classes, the enrolments could be further increased, providing room for 5,000 more students than are at present enrolled. The present number of medical schools is ample, therefore, to provide for all increases in enrolments for several years.

2. PRESENT SUPPLY OF PHYSICIANS IN THE UNITED STATES

As shown by Chart 1, in 1900 the highest number of medical colleges had been reached—more than half the world's supply—and the largest numbers of graduates were being turned out—numbers out of all proportion to the increase in population of the country. The United States was oversupplied, therefore, with both medical schools and physicians. There were then 160 medical schools, which in 1904 turned out 5,747 graduates. On the other hand, in 1920, the reduction had reached the lowest point, presenting an extreme opposite to that of 1900. There were then eighty-five colleges, and in 1922 only 2,529 physicians were graduated. The census returns of these two decades, presenting as they do the opposite extremes, should be averaged, therefore, in order to obtain an accurate idea regarding the normal supply of physicians for the United States. The average of these two extremes places the figures at approximately 4,000. Because of the rapid increase in the number of graduates since 1922, as shown in Chart 2, the census returns for 1930 will show a return to at least a normal supply of physicians in proportion to population.

3. GRADUATE MEDICAL EDUCATION

In 1916, 1919 and 1923, three complete inspections of all graduate medical schools were made by the Council on Medical Education and Hospitals, and the conditions were found to be far from satisfactory. Many of the institutions were granting pretentious, diploma-like certificates to those who had paid fees and enrolled for courses, some of which extended over only one or two weeks. Little or no record was made as to whether or not the physician actually attended the course for which he was registered. By 1923, through the suggestions given out during the previous inspections, many but not all of the postgraduate medical schools had discontinued the granting of certificates excepting for courses of six months or longer in duration.

In 1920, in order to secure a basis for the approval of graduate work, the Council appointed fifteen special committees to recommend what preparation was deemed essential to secure expertness in each of the fifteen specialties to which they were assigned. The report of these committees was presented at the Council's conference in 1921[2] and reprints of the report were sent to the officers of all graduate medical schools.

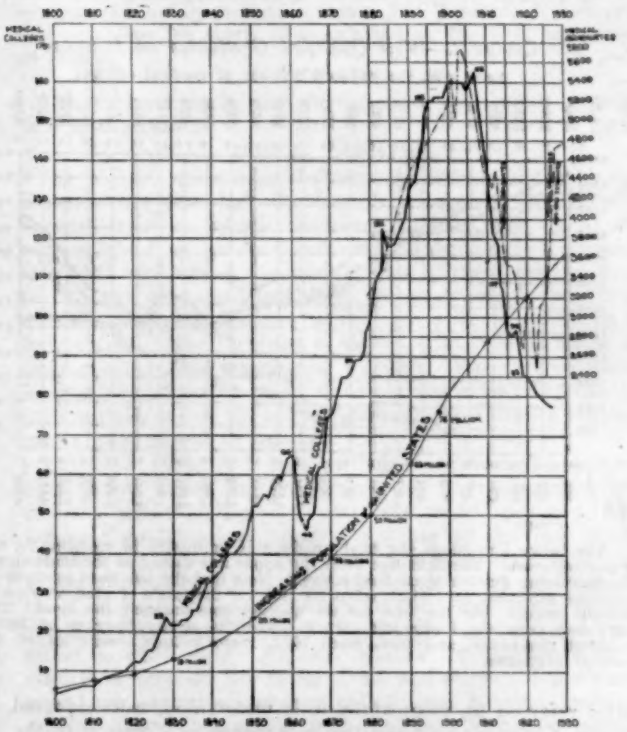
Following the inspection in 1923, the "Principles Regarding Graduate Medical Education" were prepared, were read at the Conference in March, and were included in the report to the House of Delegates in June, 1923. These principles provided for admission requirements; records; supervision; curriculum; graded instruction; qualified teachers; properly equipped laboratories; library and museum facilities; essential hospital and outpatient material; annual announcements and regulations in regard to the granting of degrees or diploma-like certificates. Reprints containing these principles were sent to all graduate and postgraduate medical schools in March, 1923.

On the basis of these principles, a list of graduate medical schools was prepared which the Council considered worthy of approval. Of the thirty-five institutions investigated, fifteen were at once admitted to the Council's approved list and eighteen have since been added, making a total of thirty-four approved graduate schools at the present time. To the list, also, has been added sixteen special hospitals which provide approved higher internships or residencies in various specialties. For admission to these residencies the graduate must have already completed an internship in a general hospital. Altogether, therefore, there are just fifty postgraduate schools and hospitals now listed as offering approved courses for physicians.

CHART 1.—*Medical Colleges and the Population*

By years, from 1800 to 1925

Medical Graduates shown also, since 1880.


MEDICAL COLLEGES
MEDICAL GRADUATES
1800 10 20 30 40 50 60 70 80 90 1900 10 20 30 40 50
MEDICAL COLLEGES
INCREASING POPULATION OF UNITED STATES

Note the colleges increased rapidly until 1900 — much more rapidly than the population — and that, since 1880, the numbers of medical graduates kept pace with the colleges. From 1904, however, the numbers dropped rapidly until since 1922 the numbers of graduates again rapidly increased while the numbers of colleges continued slightly downward. The number of graduates essential to keep the supply of physicians in a steady ratio with the population is now somewhere between 3,500 and 4,000 — an average of the upper and lower extremes.

Instead of the twenty postgraduate schools in 1916 which were offering courses of unknown quality and quantity, now there are fifty approved institutions giving courses that have been investigated and found worthy of the Council's endorsement. The Council has also prepared a list of *subjects* taught in the graduate medical schools, each subject being followed by the names of institutions in which such courses can be obtained. The physician, therefore, no longer needs to make a wild guess with regard to an institution in which he might or might not obtain the work desired. Now he has a carefully prepared list from which to make his selection.

ADVERTISING OF GRADUATE COURSES

Before the list of approved graduate schools was available, THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

2. The several fields of clinical specialization that were studied are shown in the following list. The minimum years designated after each subject represent what were considered by the committees as essential to insure efficiency in the specialties:

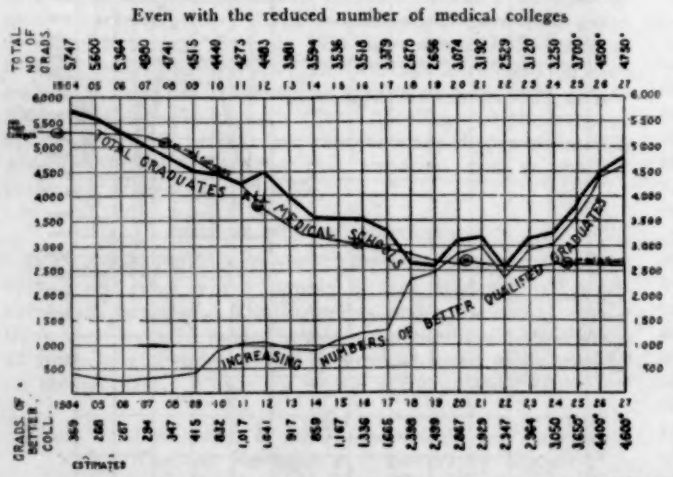
Field	Years Essential	Field	Years Essential
(a) Surgery, general	3	(g) Internal medicine	3
(b) Surgery, orthopedic	3	(h) Pediatrics	3
(c) Surgery, genito-urinary	3	(i) Neuropsychiatry	3
(d) Gynecology and obstetrics	3	(j) Dermatology	2
(e) Ophthalmology	2	(k) Public health and hygiene	2
(f) Otolaryngology	2		

was carrying the advertisements not only of a dozen or more diploma-granting postgraduate schools, but also of several very brief courses in surgery given by so-called academies, institutes, laboratories, etc., from which on expending a generous fee and a minimum of mental energy the student could secure a beautiful diploma certifying to his exceptional proficiency as a specialist in the subject named on the diploma.

Following the issuing of the Council's approved list of graduate schools, the Advertising Committee of THE JOURNAL adopted two rules: that, after Oct. 1, 1923, no postgraduate *course* would be advertised in THE JOURNAL unless it was approved by the Council on Medical Education and Hospitals; and that after Jan. 1, 1924, no graduate or postgraduate medical *school* would be permitted to advertise in THE JOURNAL unless it was approved by the Council. In July, 1923, a written notice in regard to these rules, with a copy of the "Principles Governing Graduate Medical Education," was sent by the Advertising Department of THE JOURNAL to the officers of every graduate and postgraduate medical school and to all who were offering courses of instruction of any kind for graduates in medicine. The

CHART 2.—*Well Qualified Graduates on Increase*

Even with the reduced number of medical colleges



The heavy line shows the total numbers of graduates in medicine in the respective years. The light line from the upper left corner of the chart shows the decreasing number of medical schools. Note that the two lines continue in the same direction until 1922, when the line for the totals of graduates turns sharply upward, but the line for the colleges continues on the level. The light line from the lower left corner shows the steady increase of better qualified physicians, and that, since 1922, these include almost all of the medical graduates.

rules referred to, meanwhile, it is understood, were adopted by the Advertising Committee in response to a request of the Board of Trustees and other officers of the Association, in an attempt to check an evident rush into specialization by many who had not obtained sufficient special training to warrant them in so doing.

POSITION OF THE COUNCIL

In this work, so far as the Council is concerned, there is no attempt to prevent any individual or group from offering to physicians any course of instruction they see fit, or to prevent any physician from taking any course he desires. If, however, those offering the courses of instruction desire to have the Council's approval or endorsement of the course, they should not be unwilling to comply with the reasonable principles by which the courses can be made worthy of approval.

The courses of instruction most commonly used as short cuts into specialization are those in surgery and the surgical specialties. The Council has in no way hindered the establishing of such short courses, but merely asks that they be arranged in a graded series so that the physician-student can, if he desires, take them progressively, and that eventually he will secure a training which in both time and educational content is equal to the longer courses deemed essential for proficiency in the particular specialty. All authorities conferred with in the matter of preparation in the specialties were unanimous in suggesting that an internship in a general hospital be required as the basis of such training. The Council's rules permit that, in lieu of this general internship, five years of active practice may be accepted by the officers of the graduate medical school if in their opinion the physician is otherwise qualified to undertake the graduate work.

The Council feels emphatically that no restrictions should be placed in the way of physicians who desire to improve their efficiency in general practice. It is deemed highly important, however, that certain restrictions be established to insure that those posing as specialists, and particularly in the fields requiring operative procedures, shall have secured sufficient training to guarantee a reasonable degree of efficiency in that work. Generally speaking, the Council has provided a list of graduate medical schools giving courses of instruction which the Council can conscientiously recommend to physicians who seek instruction along those particular lines. Physicians cannot afford to leave their active practices, to pay large fees or to travel long distances to enroll for courses the content and value of which are entirely matters of guesswork. They no longer need to do this if they secure the Council's list of approved graduate medical schools.

4. HOSPITAL SERVICE

The Council's work in the field of hospital service includes the securing of information with regard to all such institutions, The completeness of this information may be judged by the elaborate statistics appearing in the last Hospital Number of THE JOURNAL—that of March 28, 1925. The following items are of particular interest:

(*a*) Hospitals have been rapidly increased in number in nineteen years, from 2,411 in 1906 to 7,370 in 1925. The greatest increase in these years has been in the hospitals having from ten to twenty-five beds. The total bed capacity has increased from 217,658 in 1906 to 813,926 in 1925.

(*b*) Five years ago, 1,695, or 56 per cent., of the 3,068 counties in the United States were without hospital service. Now, 1,367, or 45 per cent., of the counties are without hospitals. That is, 328 counties have been supplied with hospitals in the last five years. It is interesting to note that in the counties which are without hospitals, there are 17,381 physicians, or one to every 1,017 people.

(*c*) The demand for interns last year seems to have been fairly well supplied. In the United States there are 871 hospitals having 4,703 interns, and 1,048 other hospitals are using 3,133 resident physicians. Only 1,563, or 21 per cent., of all hospitals are making use of 7,836 interns or resident physicians. This 21 per cent. of hospitals, however, has 435,209 beds, or 53 per cent. of the total bed supply in the United States.

(*d*) In recent years there has been a rapid increase in the number of open-staff hospitals, so that the services of hospitals are being made increasingly available for all reputable physicians in their communities. Of the new hospitals established since 1920, 83.1 per cent. report open staffs.

(*e*) During the last three years, in the conferences on hospital service particular stress has been laid on the educational function of hospitals. Besides the usual function of providing instruction for nurses, interns and occasionally medical students, attention is now being directed also to the hospital's possibilities for the further training of its staff and of other physicians by medical meetings, conferences, special clinics and the like. The hospitals can do much also toward the education of the public, through the patients who come to the hospital and through their staffs, visiting nurses and social service workers.

(*f*) Finally, the hospital now appears to be the solution of several of the modern problems in medical practice. The lack of hospitals has undoubtedly been a prominent factor in the abandonment of smaller, rural communities by physicians, as well-to-do country people are forced to go to larger towns for hospital care. More hospitals in smaller communities,

therefore, are helping to bring a wider distribution of physicians. Through their hospitals as centers for graduate medical education, such hospitals help local physicians to keep in touch with modern developments and improved methods in the diagnosis, treatment and prevention of diseases. Thus, the hospitals will help to bring the benefits of modern medical practice within the reach of a larger proportion of the public.

5. Miscellaneous Items

Several matters referred to the Council at recent sessions of the House of Delegates are referred to in this section:

(*a*) *Clinical Laboratories.*—Two years ago, the Council was requested to make a special study of clinical laboratories. From unverified information, a list of 4,069 laboratories was developed, of which 3,035 were known to be connected with hospitals and 1,034 were listed as private laboratories. A questionnaire prepared with the advice of a special committee was sent to all the private institutions. Some of the laboratories were found to have been reported under different names, some had ceased to exist, and a large number were found to be engaged entirely in nonmedical work and for these reasons 365 were eliminated from the list, leaving 669 which are still listed as private clinical laboratories. Definite information has been received with regard to 421, and efforts are still being made, directly and indirectly, to secure satisfactory information regarding the remaining 248. Through persistent efforts, it is believed that the Council will soon be in position to publish a report based on definite and reliable information.

(*b*) *Nurse Education.*—Two years ago, a committee of three physicians was appointed, which, with a similar committee of three representatives of the National League of Nursing Education, was to form a Joint Committee on Nurse Education and Service. The representatives of the American Medical Association were Dr. William Darrach of New York; Dr. Thomas McCrae of Philadelphia, and Dr. Winford H. Smith of Baltimore. The joint committee was to include also a prominent educator, and Dr. Samuel P. Capen, chancellor of the University of Buffalo, was selected for the place. When the joint committee was first contemplated, it was anticipated that ample funds for the carrying on of the essential surveys would be obtained through one of the large educational foundations; but such funds were not obtained. In order to finance the work, therefore, the committee is seeking appropriations from the several organizations interested in nurse education. This made esential also the establishing of a larger committee including representatives of the several organizations of physicians and nurses. At a meeting held in New York, Wednesday, March 4, 1925, it was decided to establish a committe of twelve delegates, one each with an alternate, from the American Medical Association, the American Hospital Association and the American College of Surgeons, and two each from three national organizations of nurses. A budget has been prepared which calls for an expenditure of $115,000 for the investigation and report. Already approximately $40,000 has been received toward the fund from various organizations. The committee has requested that the American Medical Association make an appropriation of from $1,000 to $5,000 toward this fund. This request was given consideration by the Council on Medical Education and Hospitals at its meeting held Nov. 2, 1924, and the Council recommends that such an appropriation be made. It is recommended also that Dr. William Darrach be continued as the delegate of the American Medical Association on the Hospital Committee, and that Dr. Winford H. Smith of Baltimore be the alternate.

(*c*) *Ethical Standards in Hospital Publicity.*—A resolution presented at the 1924 session by Dr. George Edward Follansbee of Ohio, which was referred to this Council, urged the cooperation of the American Medical Association with the American Hospital Association in an effort to prevent unethical advertising by hospitals. The matter was taken up with the officers of the American Hospital Association in October, and a special committee has been appointed to cooperate with the American Medical Association and the American College of Surgeons in the work for more ethical advertising.

(*d*) *Shortening the Course of Premedical Education.*—A communication from Dr. Southgate Leigh of Virginia, presented to the House of Delegates last year, suggested that a special commission be established to help in shortening the time in intermediate and high schools, if possible, so as to save two years of time in premedical work. This was referred to the Council for consideration. The Council finds that a special commission on this matter does not seem advisable, as both national and state educational associations are making rapid progress toward the desired end. In most of our larger cities, it is found that the better grade of students in grammar school are now permitted to skip one or two years, so that many students are now able to enter college at the age of 16 or 17, instead of 18. Progress toward this end is moving at an accelerated pace, as indicated by the wider provision for the so-called "junior high school," which constitutes the seventh, eighth and ninth grades but plans to take up work equal to the first three years of the high school. The so-called "senior high school" will be the tenth, eleventh and twelfth grades, but eventually the work will equal the present fourth year of high school and the first two years of college, which is now being given in junior colleges. This plan contemplates a six year elementary course and a six year secondary school course. The latter, it is believed, will complete the work now included in the first two years of college.

Summary

The subjects dealt with in the foregoing report may be thus summarized:

MEDICAL EDUCATION

(*a*) In 1900, there were 160 medical schools in the United States—more than half the world's supply—including every variety, from an openly conducted diploma-mill up to the two or three which in standards and equipment compared favorably with any in the world. Most of them were proprietary affairs conducted for profit. In many only a number of didactic, ungraded lectures were given alike to the three or four classes. The faculties of thirty or more were made up of from one to five practitioner teachers. Many were entirely lacking, or seriously so in either laboratories, dispensaries or hospitals, and in all but about thirty the entrance requirements were absent or nominal.

(*b*) Now there is a smaller but more normal supply of institutions, which in every way are well organized and efficient medical schools. Seventy-five, or 93.7 per cent., have entrance qualifications similar to those of the rest of the world; sixty-three (78.7 per cent.) are integral parts of high grade, reputable universities; sixty-two, or 95 per cent., of the four year colleges either have their own teaching hospitals (thirty-four) or have liberal privileges in other hospitals (twenty-eight) whereby efficient routine methods of clinical instruction are being given, and thirty (38 per cent.) now have groups of modern college and hospital buildings making them comparable with the best equipped medical schools of the world.

(*c*) The higher entrance requirements, the content of the medical curriculum and the duration of the medical course are not excessive, but represent a tardiness on the part of this country in the adoption of standards in our medical schools, long since required by the medical schools in Europe.

(*d*) As a result of these great changes, the expense of maintaining medical schools has indeed greatly increased; and although students' fees have also been increased, they cover less than one fourth of this increased expense.

(*e*) New problems that have arisen as a result of these great changes are: (1) a complete reorganization of the curriculum; (2) a development of more efficient methods of instruction; (3) provision for a wider election of subjects by the student, and (4) the establishing of a larger number of scholarships for the assistance of deserving students without adequate finances. These problems have been the main topics of discussion at medical conferences during the last several years. Two years ago, also, a special commission was created to make an exhaustive study of the pressing needs in medical education.

(*f*) With the tremendous changes in social conditions, due to the amazing developments in a score or more of utilitarian

and scientific fields and the greatly increased facilities for rapid transit between city and country, there has come about an unprecedented trend of all classes of people away from rural to urban communities. These changes call for extensive changes, also, in the methods of providing for public necessities in both city and country, including the benefits of modern medical service.

HOSPITAL SERVICE

(*g*) The tremendous growth in the number of hospitals, the great improvement of hospital service, and the trend toward making hospitals accessible to all reputable physicians in their communities seem to offer a solution for the more serious problems of medical practice. The building of more of them in the outlying districts will help to secure a better distribution of physicians, and the development of their educational function will help provide graduate education for the physicians in their communities.

GRADUATE MEDICAL EDUCATION

(*h*) Up to nine years ago, graduate instruction was given in institutions which, with a few exceptions, offered merely accumulations of ungraded and insufficiently described "courses" of doubtful value to the physician. Now there is a list of fifty institutions giving opportunities for graduate work, which, after careful investigation, have been found worthy of approval.

(*i*) Instead of having to make a wild guess with regard to certain postgraduate courses which might or might not provide him with the instruction desired, the physician now has the information by which he is enabled to select promptly courses that will fit his particular needs.

ADVERTISING OF GRADUATE SCHOOLS

(*j*) Since the list of approved institutions was prepared, advertisements of graduate schools or courses which are not approved have been refused insertion in THE JOURNAL.

(*k*) This action is consistent with THE JOURNAL'S policy of advertising only what on investigation is found worthy of recommendation to its readers. Approval of graduate schools is based on compliance with certain principles prepared by those expert in graduate medical teaching. These principles are entirely reasonable, and were approved by the Reference Committee and adopted by the House of Delegates in 1923. These principles, meanwhile, have been favorably referred to recently in the British medical press.

(*l*) Graduate medical education can be placed within the reach of the physicians of all communities, if the hospitals in those communities properly exercise their educational function. This can be done by special clinics, conferences and medical society meetings whereby the hospital becomes a center for such instruction.

GREAT ADVANCES IN MEDICAL EDUCATION

(*m*) The tremendous increase in the amount of definite knowledge regarding the specific causes, methods of diagnosis, prevention and cure of diseases, in the last fifty years has been no less marvelous, although possibly less spectacular, than the development of the movies, the automobile, the aeroplane, the radio and other marvelous improvements in astronomy, physics and chemistry.

(*n*) So rapid, indeed, have been the developments in all fields of human endeavor as to require not only a constant vigilance to keep informed regarding them, but also the devising of new methods whereby the essential needs of the public, both individually and collectively, can be supplied. Medical education and practice constitute only a part, although an important part, of the larger general problem.

Respectfully submitted.

COUNCIL ON MEDICAL EDUCATION AND HOSPITALS

ARTHUR DEAN BEVAN, Chairman.
RAY LYMAN WILBUR.
WILLIAM PEPPER.
SAMUEL W. WELCH.
MERRITTE W. IRELAND.
NATHAN P. COLWELL, Secretary.

REPORT OF THE COUNCIL ON SCIENTIFIC ASSEMBLY

Dr. J. S. Horsley, Virginia, Chairman, presented the report of the Council on Scientific Assembly, which was referred to the Reference Committee on Sections and Section Work:

To the Members of the House of Delegates of the American Medical Association:

The Council on Scientific Assembly has held its usual meetings since the last annual session of the Association. At these meetings, and by official correspondence in the interim, careful attention has been given to all matters that have been presented for its consideration.

ASSIGNMENTS FOR SECTION MEETINGS AT ATLANTIC CITY SESSION

Assignments for the meeting hours of the Sections at the Seventy-Sixth Annual Session have been made according to the following schedule:

MORNING	AFTERNOON
Practice of Medicine	Diseases of Children
Obstetrics, Gynecology and Abdominal Surgery	Surgery, General and Abdominal
Laryngology, Otology and Rhinology	Ophthalmology
Stomatology	Miscellaneous Topics
Pathology and Physiology	Pharmacology and Therapeutics
Orthopedic Surgery	Nervous and Mental Diseases
Urology	Dermatology and Syphilology
Preventive and Industrial Medicine and Public Health	Gastro-Enterology and Proctology

A SECTION ON RADIOLOGY

For several years, through communications addressed to the Council and through resolutions submitted to the House of Delegates, there has been expressed an insistent demand for the establishment of a Section on Radiology. This demand has been voiced most largely by representative physicians devoting themselves to this especial field of work. It is believed by many that the establishment of a Section on Radiology in the Scientific Assembly of the American Medical Association will go far toward keeping the practice of this specialty in the hands of qualified physicians and will discourage the tendency, which has become marked in some quarters, to have the practice of this specialty dominated by those who are less well qualified. Last year, two sessions in the Section on Miscellaneous Topics were devoted entirely to radiology. These were splendidly attended, and the program presented was highly commended. At this annual session, three periods in the Section on Miscellaneous Topics will be given over to this subject.

The Council has frequently expressed itself as believing that no greater number of sections should be established than now exist, and has encouraged as far as possible the reading of papers on radiologic subjects before the regularly established sections of the Scientific Assembly. But because of the success that attended the sessions held in radiology in the Section on Miscellaneous Topics last year, and because of the enthusiasm and interest of the officers appointed for the sessions to be held this year, as well as because of the importance of the whole field of radiology, the Council on Scientific Assembly recommends to the House of Delegates the establishment of a separate section to be known as the Section on Radiology, and the changing of the By-Laws accordingly.

The following officers were elected by the Council to serve as the officers of the sessions on radiology to be held in the Section on Miscellaneous Topics at this annual session: Dr. Preston M. Hickey, chairman, Ann Arbor, Mich.; Dr. Russell D. Carman, vice chairman, Rochester, Minn.; Dr. M. J. Hubeny, secretary, 25 East Washington Street, Chicago.

SECTION ON STOMATOLOGY

For a number of years, one of the regular sections of the Scientific Assembly has been the Section on Stomatology. The registration at the meetings of this section has been consistently small, so that at no time has there been a sufficient number of orders for the transactions of the section to justify publication. The programs of the Section on

Stomatology are tending more and more each year to deal with oral surgery, and subjects pertaining to general medicine. It is the sense of the Council on Scientific Assembly that the Section on Stomatology be abolished and that when, in the opinion of the Council, it may be advisable, sessions on stomatology shall be held in the Section on Miscellaneous Topics. The Council recommends to the House of Delegates that the action indicated above shall be taken at this session and that the By-Laws be amended accordingly.

VACANCIES IN SECTION OFFICES

At the last annual session, the Council recommended the amendment of Section 2, Chapter XIV of the By-Laws to provide for filling any vacancy that might occur in section offices, and submitted the following proposed amendment:

Amend Section 2, Chapter XIV, of the By-Laws by inserting, after the seventh line in Section 2, the words: If any vacancy occurs in the office of chairman, vice chairman or secretary of a section, such vacancy shall be filled by the election by the executive committee of such section of a Fellow who shall serve in the office indicated until the next annual session.

This matter was referred to the proper committee, but for some reason was not reported on. The Council renews its recommendation with respect to the indicated amendment of the By-Laws.

ANNUAL CONFERENCE OF SECTION SECRETARIES

The Annual Conference of Secretaries of the Sections with the Council on Scientific Assembly was held in Chicago, Dec. 16, 1924. Every section was represented at this conference, at which there was a thorough discussion of various plans proposed for improving the work of the Scientific Assembly.

The success of the program of a section is sometimes interfered with by the fact that those who accept assignments fail to be on hand to present their papers when their names are called. Among other suggestions offered with respect to this situation was one to the effect that any person accepting an assignment on a section program and failing to be present to read his paper at the time designated, without a reason entirely satisfactory to the officers of the section concerned, should not be placed on the program for at least two years after the session at which he failed to keep his engagement.

It was the sense of the conference that the number of papers on any session program should be kept well below the limit of twenty-five provided for in the By-Laws.

The conference recorded itself as believing that the exhibit of fresh pathologic material at the Chicago Session in 1924 was a splendid innovation, and that similar exhibits should be had whenever possible at future sessions of the Association.

With respect to the approval of nominations for Associate Fellowship, the section secretaries recorded their opinions that such nominations should lie on the table for one year before being finally acted on by the House of Delegates.

The Council wishes to express its appreciation of the splendid service rendered by the officers of the sections of the Scientific Assembly and especially to commend the efforts of the secretaries of these sections, on whom most of the labor involved in the preparation of programs and in other affairs of the sections is imposed.

Respectfully submitted.

J. SHELTON HORSLEY, Chairman.
J. E. LANE.
E. S. JUDD.
ROGER S. MORRIS.
F. P. GENGENBACH.
W. D. HAGGARD, President-Elect.
MORRIS FISHBEIN, Editor, THE JOURNAL.
OLIN WEST, Secretary.
} Ex officio.

ADDENDUM

(Refer page 1655, following Trustees' Report)

Report of the Council on Medical Education and Hospitals

The report of the Council on Medical Education and Hospitals was given by Dr. Ray Lyman Wilbur, in the absence of the Chairman, Dr. Bevan, and included the following resolution (not previously incorporated in the printed report of the committee):

Resolved, That the membership of the Council be increased to seven members and not more than nine, the term of office to remain at five years as at present, and that no more than two new members be appointed in any one year except in the filling of any unexpired terms.

The report of the Council on Medical Education and Hospitals was referred to the Reference Committee on Medical Education, with the exception of the resolution asking for an increase in membership, which was referred to the Reference Committee on Constitution and By-Laws for an amendment to the Constitution and By-Laws.

Report of the Council on Scientific Assembly

Dr. J. Shelton Horsley, Virginia, presented the report of the Council on Scientific Assembly, and read two amendments offered by the Council not included in the printed report: (1) that the word "radiology" be added to Chapter XIV, Section 1, of the By-Laws; (2) in regard to establishing officers when a new section is created, adding the words "and for the first session of a new section," so that it will read "to appoint officers for meetings making up the Section on Miscellaneous Topics and for the first session of a new section."

The report of the Council on Scientific Assembly was referred to the Reference Committee on Sections and Section Work, except that part pertaining to amendments to the Constitution and By-Laws, which was referred to the Reference Committee on Constitution and By-Laws.

New Business

RESOLUTION ON LIFE EXTENSION INSTITUTE

Under the head of New Business, Dr. Albert E. Bulson, Jr., Indiana, offered the following resolution, which was referred to the Judicial Council for action:

WHEREAS, At the last meeting of the House of Delegates of this Association held in Chicago, in June, 1924, the Judicial Council presented a report dealing with an important economic principle affecting the public and the medical profession, and,

WHEREAS, The Life Extension Institute of New York has taken occasion openly to question the honesty and truthfulness of the report of the Judicial Council concerning this matter, and,

WHEREAS, This open expression of opinion in questioning the honor and integrity of the members of a valuable Council of this Association is, in a sense, a reflection on the Association, be it

Resolved, That the Judicial Council be asked to present to this House of Delegates any information or proof that will vindicate its position as taken in the report presented at the Chicago Session, so that suitable action may be taken by this House.

RESOLUTION ON DISASTER RELIEF

The President, Dr. William Allen Pusey, read a resolution on the establishment of an organization for relief during disasters, which was referred to the Reference Committee on Hygiene and Public Health.

RESOLUTION ON MEDICAL ETHICS

A resolution recommending penalties for violation of ethics, presented by Dr. Albert Soiland, California, was referred to the Judicial Council.

RESOLUTIONS ON COSMETICS

A resolution read by Dr. H. M. Hazelton, Ohio, on the use of cosmetics, was referred to the Reference Committee on Hygiene and Public Health. The resolution reads:

WHEREAS, There has been an enormous increase in the use of cosmetics, and,

WHEREAS, Many of these cosmetics contain chemicals irritating and even dangerous to the human organism, and,

WHEREAS, A special committee of the American Medical Association is now in existence, appointed to investigate these problems, be it

Resolved, That the trustees of the American Medical Association be urged to finance and push the work of this special committee.

RESOLUTIONS ON BY-LAWS

A resolution read by Dr. George F. Keiper, Indiana, was referred to the Reference Committee on Constitution and By-Laws.

Three additional resolutions were presented by Dr. Keiper and were referred to the same Committee:

Amend Chapter 14 of the By-Laws by inserting a new section as follows:

"Any Fellow accepting an assignment on a section program and failing to be present to read his paper at the time designated, without valid reasons, shall be debarred from a place on any section program for a period of two years after the session at which he failed to keep his engagement."

(Number this Section "14," and renumber present Section 14, "15.")

Amend Section 2, Chapter 14 of the By-Laws. After the seventh line in Section 2 insert the words:

"If any vacancy occurs in the office of Chairman, Vice Chairman or Secretary of a section, such vacancy shall be filled by the election, by the Executive Committee of such section, of a Fellow who shall serve in the office indicated until the next annual session."

Amend Article 10—"Annual Sessions"—of the Constitution by inserting the word "Canada" after the words "United States" so that the last clause shall read:

"A session may be held at any place in the United States or Canada."

Amend Chapter 12 of the By-Laws—"Registration"—last paragraph, by substituting the word "two" for the word "one" and for the word "section" substitute the word "sections," and add the words "provided there is no conflict of time between the meetings of the sections," so as to read:

"A Fellow on registry shall designate the section in which he wishes to be enrolled but shall be enrolled in two sections only at any scientific meeting, provided there is no conflict of time between the meetings of the sections."

RESOLUTION ON VISITING OF COUNTY SOCIETIES

A resolution presented by Dr. Victor G. Vecki, California, was referred to the Board of Trustees for reference back to the House:

Resolved, That, in order to protect the best interests of the public, and promote the welfare of the general physician:

1. Each and every properly elected delegate to the House of Delegates of the American Medical Association be appointed a committee of one, whose duty it will be to visit as an official representative of the American Medical Association each county unit in his district at least once during each calendar year.

2. The American Medical Association will use all of its resources in assisting delegates and committees in informing county medical societies as to impending legislation unfavorable to the application of medical science to the relief of the sick and injured, and as to the progress and method of enacting laws favorable to the proper practice of medicine.

3. Each delegate or committee must report in writing to the proper bureau office at the headquarters of the American Medical Association the results of such visits.

RESOLUTION ON ALCOHOL

Dr. Thomas Clark Chalmers, New York, presented two resolutions, on the prescribing of alcohol and narcotics, both of which were referred to the Reference Committee on Legislation and Public Relations. Part of one of the resolutions which referred to the expenditure of funds was referred to the Board of Trustees.

RESOLUTION ON MEDICAL TAXES

A resolution on the special medical taxes presented by Dr. Tate, Ohio, was referred to the Reference Committee on Miscellaneous Business:

WHEREAS, Several federal taxes unfairly discriminate against physicians, and

WHEREAS, Most war taxes have been abolished, and the tax on the medical profession under the Harrison Narcotic Act remains, and,

WHEREAS, The Federal Revenue Act of 1924 authorizes the deduction of all ordinary and necessary expenses paid or incurred in carrying on any trade or business before the computation of federal income taxes, and in spite of said provisions the commissioner of internal revenue denies the right of physicians under the statute any such deductions so far as relates to traveling expenses incurred in attending meetings of medical societies, or for expenses of postgraduate medical study, therefore be it,

Resolved, That the House of Delegates of the American Medical Association at the 1925 annual meeting, urges on the President, the Secretary of the Treasury, the Commissioner of Internal Revenue and the members of the Congress from Ohio that steps be taken to reduce or abolish tax burdens unjustly imposed upon the medical profession, namely:

1. *The tax under the Harrison Narcotic Act;*
2. *Denial of exemption on traveling expenses necessary for attendance at meetings of medical societies;*
3. *Denial of exemption on the expense of post-graduate study;*

and further be it

Resolved, That the officers of this Association be requested, and are hereby instructed, to take whatever steps are considered most effective in carrying out the purpose of this resolution.

RESOLUTION ON LISTING PHYSICIANS IN TELEPHONE DIRECTORIES

A resolution presented by Dr. Wells Teachnor, Ohio, was referred to the Reference Committee on Miscellaneous Business:

WHEREAS, The Ohio Bell Telephone Company has established the heading "Physicians and Surgeons M.D.," for the classified list of physicians and surgeons in the telephone directory of the Cleveland district, and,

WHEREAS, The American Medical Association believes this to be an important step in educating the public to the difference between a licensed doctor of medicine and a limited practitioner, be it,

Resolved, By the House of Delegates that the proper officials of the American Medical Association request the American Bell Telephone Company to establish this heading for the lists of physicians and surgeons in all its directories throughout the United States, and, be it further,

Resolved, That the American Medical Association expresses its belief that such list should be open only to men and women licensed as Doctors of Medicine in the various states and territories.

RESOLUTION ON PERIODIC PHYSICAL EXAMINATIONS

A resolution presented by Dr. Orrin Sage Wightman, New York, was referred to the Reference Committee on Hygiene and Public Health:

Moved by Dr. O. S. Wightman of New York:

"That, owing to the nation-wide need and interest in periodic health examinations, this matter be referred to the proper committee, which shall suggest a committee with power to call a conference of those interested and active in this work throughout the Union, at such time and place as seems best to correlate the work already done and devise a nation-wide plan for adoption."

RESOLUTION ON INVESTIGATION OF APPARATUS

A resolution presented by Dr. Joseph F. Smith, Wisconsin, for appointment of a Council on Physical Therapy, was referred to the Reference Committee on Miscellaneous Business.

RESOLUTION ON AD INTERIM MEETING OF HOUSE OF DELEGATES

A resolution presented by Dr. Wells P. Eagleton, New Jersey, was referred to the Board of Trustees:

1. In accordance with instructions of the House of Delegates and the Board of Trustees of the Medical Society of New Jersey, the following resolution, which was passed at the Annual Meetings in 1923 and 1924, is hereby offered. (See Transactions of the Medical Society of New Jersey, Supplement to Journal, September, 1924, page 27.)

"*Resolved*, That the Delegates of the Medical Society of the State of New Jersey use their influence and vote that the following words be added to Chapter III, Section 1 of the By-Laws."

2. That an ad interim meeting of the House of Delegates of the American Medical Association be held at the headquarters of the Association annually. It is impossible for the House of Delegates to do their duty by the Association by having meetings but once a year.

RESOLUTION ON CARE OF WAR VETERANS

A resolution presented by Dr. Ben R. McClellan, Ohio, was referred to the Reference Committee on Legislation and Public Relations:

(Relating to the Word War Veterans' Act of 1924)

As THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION has pointed out: "There are thousands of veterans of the various wars specifically mentioned in the act who are abundantly able to pay for medical service, and no doubt by far the largest number of them are perfectly willing to pay for whatever may be done for them. There are, on the other hand, many who will be willing to take full advantage of the provisions of the act, so far as it relates to the receiving of free medical and hospital care." The duty of the government to care for those whose disabilities arose in or through military service is clearly recognized. The establishment of the practice of giving medical and surgical aid to those whose disabilities were not incurred in or through their military service is severely condemned. This resolution meets the approval of your committee, and is recommended for adoption.

WHEREAS, The World War Veterans' Act of 1924, Subsection 10 of Section 202, provides for hospitalization, medical and surgical service, and necessary traveling expenses "to veterans of any war, military occupation, or military expeditions since 1897, not dishonorably discharged, without regard to the nature or origin of their disabilities," and,

WHEREAS, Under the terms of this act, a large number of men are to be provided with hospital care, medical and surgical treatment, at government expense as long as they live, for disease and injuries, without regard to the origin of such diseases and injuries, whether incurred in military service or not, and without regard to the financial ability of the man to pay for the needed attention, and,

WHEREAS, The benefit conferred is illogically distributed, in that the receipt of the benefit is dependent on the ability of the beneficiary to leave work, family and home, and not on financial ability, nor on the nature of the disease and,

WHEREAS Such beneficiaries must be kept in government hospitals until they are completely recovered even though they might be more economically and better cared for at home, because of the provision in the law that the government will house, feed and nurse them and will provide them with medical and surgical attendance so long as they remain in hospitals, but will not contribute in any way toward their relief after they leave the hospital, provided the incapacity is not due to military service, therefore, be it

Resolved, That the House of Delegates of the American Medical Association in annual convention of 1925, express its disapproval, with this provision of a federal law which furnished government subsidy tending to deprive the sick and injured from the privilege of engaging physicians and surgeons of their own selection in their home communities, and, be it further

Resolved, That we disapprove the plan of furnishing financial aid or personal service to beneficiaries able to pay, as tending to pauperize an independent, self-supporting part of our citizenship, and, be it further

Resolved, That such subsidizing as proposed is an unjust and unneeded tax on a people already overburdened by government expenditures, and be it further

Resolved, That any such subsidies be limited to those veterans whose disabilities have arisen from and in the course of military service, and be it further

Resolved, That these resolutions be referred to the Board of Trustees for further action.

Address of President-Elect William D. Haggard

The Speaker introduced the President-Elect, Dr. William D. Haggard, who delivered the following address, which was referred to the Reference Committee on Reports of Officers:

Mr. Speaker and Members of the House of Delegates:

Medical education in the United States has had the most remarkable change in the last fifteen years that has ever been witnessed. It was inaugurated by the work of the Council on Medical Education of the American Medical Association, and the survey made by the Carnegie Foundation for the Advancement of Teaching in 1910. Nothing can be added to the medical course at the present time. It is very complete, and if there is any criticism at all, it is probably too highly technical. Not much relief can be expected from the medical colleges themselves, as they are doing the best they can. It should be the function of the House of Delegates, which is the legislative body of the American Medical Association, to make some effort to curtail the length of medical education at the present time, not with the view of making it less complete, but of encompassing it in a shorter time. It is well known that the average age of the man entering practice now is 27, or 28, which is too advanced an age. Economic conditions prevent a man from carrying the financial load so long. Many of them do it with large debt to hamper their early years of practice, and some become discouraged and fall by the wayside. Some plan should be evolved by the House of Delegates that will save one or two years in the average time at which the medical student enters practice. One year, at least, could be saved in the high school. This is being done in many high schools by the four quarter period during the year without a compulsory three months annual vacation, so that a sudent can save that time, and graduate at an average age of 16 or 17. Most of the work in the first year of high school is an epitome of the work in the grammar school. The first year in college is largely a review of high school. In the medical school the work could be accomplished in three, three and a half, or three and three-quarter years, if two things were provided: first, the four quarter system, which certainly a few schools could manage very easily, and, second, some change and uniformity in the requirement of state boards of licensure about the period requisite for graduation.

MEDICAL PRACTICE ACTS

While the Model Practice Act may not be in operation in all states, yet so far as the provisions and requirements for the regular practice of medicine are concerned, they are adequate. The difficulty has been in allowing separate cults like the osteopaths and chiropractors to have their separate boards for examination. You will say that we always have had cults and pretenders and men who use a short cut to practice medicine and that we always shall. We have witnessed the rise and fall of homeopathy, of eclecticism and of osteopathy. We can see the same future for osteopathy that has befallen homeopathy. In another one or two decades perhaps chiropractic will be in about the same relative position that osteopathy is now. But what about the people meanwhile? I realize it is always difficult to control the cults in medicine. However, we should never stop in the endeavor to get a fundamentally sound law to require the same examination in the elementary branches of physics, chemistry, anatomy, physiology, pathology and diagnosis that should be required of every one who undertakes to treat the sick. This is an exemplification of the square deal that is the slogan of Americanism, and the profession must never rest until this has been accomplished.

LEGISLATIVE ACTIVITIES

If laws are enacted inimical to public health and derogatory to the medical profession and jeopardizing its development, the profession has no right to blame Congress or any state legislature, unless it has brought the situation to their attention in a timely, intelligent and effective way. To do this requires effective organization and machinery; for without such organization and machinery, it is impossible to know what is going forward in a legislative way, to determine promptly sound policies for the profession with respect to such matters, and then to make the voice of the profession heard and its influence felt in legislative bodies with respect to them. If I seem overinsistent in the matter of organization, it is because of the individualistic character of the physician's work and his too frequent failure to appreciate the importance of mass action to achieve results. Effective leadership is necessary, and active committees; and the individual physician must be ready to accept the duly established policies of the profession, unless matters of conscience are involved. He must be prepared, too, to do his part toward presenting the views of the profession to his legislative representatives in federal, state and municipal legislative bodies; for in no other way can they be instructed so effectively concerning the views of the profession as through correspondence and conference with the very persons whom they represent.

Each and every one of us should constantly remember and act on the principle so aptly expressed:

> It is not the individual,
> Or the army as a whole,
> But the everlastin' team-work
> Of every bloomin' soul.

MEDICAL DEFENSE

The increasing frequency of suits against physicians based on alleged malpractice is cause for grave concern. The medical profession should not, and will not, stand in the way of settlement for any just claim. But the present situation calls for a careful study of every case, just or unjust, to determine its origin. Claims that are not only unjust but also fraudulent should be fought to the bitter end, and so far as such frauds may be traced to any member of the bar, the matter should be referred to the bar association for appropriate action. Something may be done, possibly, to limit the filing of fraudulent suits by arriving at a proper understanding with the local press. While no complaint can be made of the general attitude of our newspapers with respect to the publication of news concerning malpractice suits, yet occasionally some such papers, usually the smaller newspapers in relatively small communities, offend; and it is with these very cases that premature publication does the greatest injury. If editors always understood the extent of the injury worked by the simple publication of the fact that a malpractice suit had been filed against a physician and realized that the blackmailer, to force a compromise of an unjust claim, relies on the physician's fear of such publication, they would be loath to

lend their column to an unjust cause. When a demand made for hush money approaches the point at which there is a probability that a suit will be filed, the situation may well be carried to the attention of the local press with a view of forestalling publication. To carry into effective operation such suggestions as offered above requires, however, organization and yet more organization, for organization is in the end the bulwark on which not only the profession generally, but also the individual physician must rely.

WORKMEN'S COMPENSATION ACTS

It is gratifying to note a widespread tendency during recent years toward enlarging, or even removing, the limits on the duration and cost of medical service allowed injured employees under our various workmen's compensation acts. It is remarkable, however, and exceedingly unfortunate, that so much of the legislation of this character has been enacted apparently without any conception of the important part the medical profession must play under it. Each case arising under the Workmen's Compensation Act is a medical case. A report issued by the National Industrial Conference Board, after a study of the workmen's compensation acts of the United States says:

> Even today after the experience of a decade in the operation of these laws, only fifteen of the forty-two states with workmen's compensation laws have physicians attached to the administering board in any official capacity other than that of examining or impartial physicians who render opinions on the physical condition of the claimant. Such physicians have no authority to consider other questions relating to the case. In half of the states having medical departments the medical adviser devotes only a portion of his time to this work. In only one state is a physician a member of the administrative board.[1]

That under the conditions stated the medical profession should have grievances under these laws is not remarkable: grievances because of the narrowness with which they provide for the medical care of injured workmen, because of their denial of the right of the injured workmen even to choose his own physician and because of their general tendency to deny to the workmen the confidential relations secured to patients generally under the various statutes that have been enacted with respect to privileged communications.

Possibly the immediate goal the medical profession should seek is to establish its proper status under the laws. What such status should be has been well set forth in a report made to the National Industrial Conference Board by its medical adviser, the Conference Board of Physicians and Industry, as follows:

> *Medical Director.*—There should be attached to each compensation commission a physician who should be the medical director. He should be appointed from a group of at least three physicians proposed by the state medical society as being qualified for the position.
>
> *Consulting Staff.*—A consulting staff of recognized specialists should be appointed from a group proposed by the state medical society to advise the commission regarding the treatment of cases, the estimation of degree of defect, and other matters touching on medical questions. This consulting staff should be nonpolitical, and its members should be paid for the actual time spent in compensation work.
>
> *Examining Physician.*—Examining physicians should be appointed by the commission after being recommended for the position by the consulting staff on the basis of their scientific qualifications. Such physicians should make examinations of injured workers on order of the commission. Their fees and expenses should be approved and paid by the commission.[2]

The denial of the right of the patient to choose his own physician or surgeon when injured is un-American, unwise and a step toward "state medicine." The law did not intend this at first, but only to provide that an examining physician representing the employer should be allowed to examine the patient from time to time. That part was all right; but when it comes to compelling the injured man to have any physician dictated by the company, and his own physician prohibited from taking care of him, it is a manifest injustice to both. It is not true with liability insurance for automobiles, etc., which is so prevalent in this country.

The right of the injured employee to choose his own physician has been restored in the states of Ohio and Massachusetts, and in a number of other states this right has been preserved. It should be so in every state.

1. National Industrial Conference Board: Workmen's Compensation Acts in the United States: The Medical Aspect, Research Report 61, 1923, p. 258.
2. National Industrial Conference Board, Inc.: Uniform Medical Provisions for Workmen's Compensation Acts in the United States, Special Report 31, 1925, pp. 16-18.

THE MEDICAL CARE OF THE VETERAN

In the Veterans' Act, Paragraph 10, Section 202, of public document 242 of the Sixty-Eighth Congress, being the World War Veterans' Act of 1924, approved June 7, 1924, on page 16, the following appears:

> The director [of the Veterans' Bureau] is further authorized, so far as he shall find government facilities permit, to furnish hospitalization and all necessary traveling expenses to veterans of any war, military occupation or military expedition since 1897, not dishonorably discharged, without regard to the nature or origin of their disabilities.

Under the terms of this act, a large number of men, without regard to their financial status, are to be provided with hospital care and medical and surgical treatment at government expense, as long as they live, for all diseases and injuries, without regard to the origin of such diseases and injuries. The only condition is that they leave family, friends and employment, and enter a government hospital. This looks very much like "state medicine," pure and simple. It requires only one step more, too, to confer similar privileges on the wives and the widows, and on the children, of the beneficiaries under this act; and such a step would not be inconsistent with what has already been done, as the benefit conferred is not dependent on any relation between the disease or injury and military service.

The benefit conferred is, morever, illogically distributed; for it makes the receipt of the benefit dependent on the ability of the beneficiary to leave work, family and home, not on financial ability nor on the nature of the disease. A veteran in the early stages of disease, who is as yet able to continue at work, cannot receive any benefit unless he leaves his employment; and this he may be unable to do, because the law does not provide for the support of his family during his absence. Other veterans, who by reason of distance or family ties are unable to enter a government hospital, or who because of the serious nature of their illness or injuries cannot be transported to a government hospital, cannot benefit by the provision of law set forth above. The convalescent veteran must be kept in the hospital until he has completely recovered, even though he might be much more economically cared for at home, because the government will house, feed and nurse him, and will provide him with medical and surgical attendance, so long as he remains in the hospital, but will not contribute a penny toward his relief after he leaves, if his incapacity is not due to military service.

This provision of law is bad, furthermore, in that it is in substance a government subsidy tending to withdraw the sick and injured from the care of physicians and surgeons scattered throughout the country, who depend for their very living on having sick and injured to treat. Their patients will be attracted away by the government gratuity this law provides, making practice in small towns and in the country even less attractive than it is now.

The scheme is one that should be made general in its application to all veterans, if it is to be adopted at all. Instead of compelling sick and injured veterans to resort to government hospitals for government treatment, cash benefits should be provided, and such veterans should be allowed to provide their own medical and surgical treatment, and their own hospital care, in their own places of residence.

Incidentally, the illogical character of this legislation is shown by the fact that medical and surgical treatment, and hospital care, are no more necessaries of life than are food, clothing, fuel and shelter. If logically the government is to provide medical and surgical treatment and hospital care, regardless of the financial ability of the veteran to pay for them and without regard to the origin of the disease or injury, the government should by the same reasoning provide food, clothing, fuel and shelter. It would be interesting to know what the taxpayer, the grocer, the clothing dealer, the fuel man, the landlord, would say to a proposition of this kind.

An effort was made at the last Congress to amend the World War Veterans' Act by H. R. 10271, but it failed.

It is obvious that there are thousands of veterans who are able and willing to pay for their medical service. It surely

could not be the intent of the bill to pauperize nearly five million Americans by giving them free medical care for any and all ailments irrespective of their origins. Only a minority of the ex-service men would favor such a drastic change in the economic situation of the medical service of this country. Already a government hospital at Memphis which had only fifty beds before the enactment of the World War Veterans' Act has now 325 beds and is running practically full. Approximately 75 per cent. of its inmates are being treated for conditions in no way connected with their military service. It is apparent that this will continue as people become familiar with the provisions of this act. If carried out to its logical conclusion it would be an unlimited drain on the resources of our government and on the already overburdened taxpayers. All previous pensions and other governmental expenses will sink into insignificance compared to the stupendous enormity that is possible under this act.

An amendment should be undoubtedly made to restrict it to those veterans who are unable to pay for their services and to be determined in some definite manner. No group of men in our nation gave more unstintedly of their services and made more sacrifices than the medical profession. More than 35,000 men were in the service. They have now and ever have been willing to live up to their ideal that no one is too poor for their ministrations. For the economic welfare of the nation and the proper relation of the profession and the government each to the other and to the sick of this country, the objectionable features of the intended benevolence to our deserving veterans should be corrected.

The American Medical Association must take cognizance of this individually and as a body. I can recommend no more urgent matter to the attention of the House of Delegates for its interpretation and action than this question of such stupendous moment.

Address of Dr. J. Basil Hall, President, British Medical Association

The official delegate of the British Medical Association, on being introduced, spoke as follows:

Mr. President, Mr. Speaker, Members of the House of Delegates:

I esteem it a great privilege to come here as a representative of the British Medical Association and bring you our fraternal greeting and hearty good wishes for your prosperity and success. I should like also to touch just one personal note and to say that I want to thank you all most heartily, and especially my friend, your President, for the very warm-hearted welcome and generous hospitality which has been accorded to me since I came to this country.

I find myself in rather a difficult position. I did come to learn as much as possible about the American Medical Association, but I have just come to the conclusion that the time I have allotted for the task is far from sufficient, and the only solution to my difficulty is that I shall have to come again. (Applause.) I must be back in London early in June, and I shall have to sail this week, but I do hope that I shall see many of you in that small city very shortly, and I can assure you you will get a very warm welcome—as warm as the the stolid Englishman can give.

Sir Robert Jones, whom you all probably know as our great orthopedic surgeon, was walking down The Strand the other day, and he sudenly ran into one of the Mayos. "Hello, Mayo!" he said, "What are you doing here?"

"Oh, Jones, I'm glad to see you. I've been in this place three days and you're the first person that has taken any notice of me."

I think you know, gentlemen, that that is a peculiarity of our nation, and you must not take it too seriously.

When I think of the fact that you have really been existing or rather reconstructed some twenty-five or twenty-six years, I am very much astonished at the amount of work which you have succeeded in accomplishing during that period. I have been listening to lists of members who are appointed on committees, and I have come to the conclusion that you have far more committees than we have and I think you are doing more work. We think we work pretty hard; I am sure some of our council meetings seem to me sometimes as though they are going to extend out to the crack of doom, but the amount of work which you appear to be doing is very great indeed, and I am not going to detain you from that by any long speech.

I am going to tell you a story, and it is a story with a moral. I think that moral is one which should always be borne in mind in every association. Your constitution, though somewhat like ours, has certain very fundamental differences, and one of the great differences which appears most important to me is that your delegates come from state societies which extend over an enormous area of the country and have their own interests to consider and, therefore, are difficult to be kept together in a united state. That, it appears to me, is a great difficulty in which you have to contend and one which I am thankful to say does not concern us in England.

You all know that in 1912 the medical profession in England was suddenly brought face to face with the national health insurance act. Whatever might be said at that time to the contrary, there was no doubt that really it was the shadow or might be the shadow of a state service, a condition of things which we all abhorred. The British Medical Association had been jogging along very comfortably for a great many years. It was poorly organized at that time. I think anybody would admit that. It was suddenly called upon to meet this great question. The members of this association disliked the idea of contract service with the government very much indeed, and there was a great outcry and we were not going to submit to it. If we had been well organized and if we had been thoroughly united throughout the British Isles, I am sure that that act would have had to be very much modified if not actually withdrawn by Mr. Lloyd George, but our organization was not complete enough and it was too weak to withstand political pressure. Mr. Lloyd George said that if the medical profession as a whole did not come in to work with this act and along the suggested lines, he had up his sleeve sufficient medical men to establish a state service and work it on the lines which we wished to avoid of all others.

Men began to fall away, the organization tumbled to pieces, and finally there was a grand panic and every one went into the act. It was rather a pitiful spectacle, not because we went into it, but because we went into it after we said that we wouldn't

The British Medical Association came in for a good deal of abuse; they said we had been weak; they said we had not advised the members wisely, and there was a good deal of mud thrown at us.

That was nearly thirteen years ago. During those thirteen years we have learned better. We have organized the association until now I think it is true that it is one of the strongest trade unions in the British Isles, as a great many people say about it. But it is a trade union in a proper sense. It is a trade union that is not simply out to get the most out of the public at the least possible labor. During the last twelve or thirteen years the British Medical Association has worked most assiduously to make the national health insurance act a good act, to make it practical and to make it give to the working man the best medical attention possible, and to look after his welfare.

At the outset and prior to the war I think that each panel physician received seven shillings or seven and sixpence for every patient on his panel list; that is nearly $2. During the war the payment was raised quite naturally and properly on account of the enormously increased cost of living, until each panel doctor was receiving twelve shillings and sixpence for every name on his panel list. That, of course, is irrespective of whether he was actually attending them or not. It was a contract paper.

Recently, nearly two years ago, the government said that the payment must be reduced, that the cost of living had

fallen, that twelve and sixpence was too much. Everybody agreed to that. The whole question was how much it was going to be reduced. The minister of health, Mr. Johnson Hicks at that time, after some consideration said that he was going to pay seven shillings and sixpence. The British Medical Association Committee that had been sitting considered the matter and said that the payments should be nine shillings and sixpence. The great friendly societies who were interested in the financing of the act said that they thought six shillings was quite enough for any doctor.

The British Medical Association approached the minister of health and persisted in their request that the payment should be nine shillings and sixpence, but they received the reply that he could not see his way to allow that. They said they would be perfectly willing to have arbitration and have the whole matter discussed by an independent authority.

The minister of health was a little truculent and said that he had no use for abritration, he had made up his mind that it was going to be seven and six and they would have to take that. The British Medical Association replied by suggesting that he might find himself without any panel doctors to carry out the act. The retort to that was that the medical men tumbled into the act quickly enough after Mr. Lloyd George first introduced it and he thought they would fall into line again.

The British Medical Association then sent out forms to all the panel doctors throughout the Kingdom which were forms of resignation, and within ten days the minister of health received 96 per cent. resignations. He was left with 4 per cent. of the doctors to carry on the act. He then said he thought arbitration was not a bad thing after all.

A commission was formed to investigate the whole question. After having sat for a great many days, during which Dr. Brackinberry, chairman of the Panel Committee, conducted the case for the association, the counsel for the government on the other side congratulated us on the way in which the case had been conducted, and the arbitration awarded nine shillings per patient, that award to remain in force for five years.

I am just telling you that because it is a great object lesson and one which, however strong you may feel yourselves to be, you should bear in mind. If you will be united you can do anything; if you are not united you do nothing except make exhibitions of yourselves. That is why I say you are up against a difficulty much greater than that which we have had in England, because, as I understand your constitution, this House of Delegates is composed of representatives from different states which must have their own interests largely to consider, states that are spread wide apart over great distances. If I would say anything to you now, it is just this to each of you, to remember that your duty is to seek the greatest good for the greatest number, and if sometimes matters come up for discussion among you and the general feeling is something which does not quite fall into line with what you would wish for in that particular part of the world from which you come, let me beg of you always to remember that after all you are here for the good of the American Medical Association which represents the profession at large, and you must always be prepared to let local interests give way as far as possible to that great object.

Your Association is the greatest association in the world; there is no association which contains anything like the number of members which you have on your lists, and you can be a very great, powerful good, not only to the profession to which you have the honor to belong, but to the world in general.

I thank you very much indeed, sirs, for your kindly welcome to me today. I shall go back home at the end of the week and tell them in London that we have still a good deal to learn on this side of the water, and I think that one of us ought to make it a point of coming here every year and gathering some further knowledge. (Applause.)

Address of Dr. T. C. Routley

The Secretary, Dr. West, introduced the secretary of the Canadian Medical Association, Dr. T. C. Routley, who addressed the House.

New Business (Continued)

NEW APPOINTMENTS ON REFERENCE COMMITTEES

On the Committee on Credentials to succeed Drs. Taylor, Waterman and Johnson, the Speaker appointed Dr. H. P. Beirne, Illinois; Dr. A. J. Bedell, New York, and Dr. J. C. Lyter, Missouri. The Speaker also appointed Dr. Chalmers, New York, a member of the Reference Committee on Legislation and Public Relationship, to act as chairman of that committee until the arrival of Dr. Donald Macrae of Iowa.

RESOLUTION ON MEDICAL TAXES

A resolution was presented by Dr. Charles O'Donovan, Maryland, which was referred to the Committee on Legislation and Public Relations:

At the ninetieth meeting of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland, April 29, 1925, the following minutes were adopted and it was the unanimous vote of the House that our action taken be communicated to the proper authorities. The following reduction in tax burdens was considered in detail by the assembled delegates and it was urged to have these taxes reduced or rescinded when the matter is submitted to Congress next December. The three following taxes are given in detail with an explanation of our stand in each one for your information:

1. *The War Tax Under the Harrison Narcotic Law.*—A tax under the Harrison Narcotic Law is necessary to enable the United States government to retain jurisdiction over intrastate matters arising under it. The one-dollar tax originally imposed was ample for this purpose, the constitutionality of the law having been sustained by the United States Supreme Court while the one-dollar tax was in force. The three-dollar tax was first imposed by the Revenue Act of 1918, as a part of the general scheme to increase taxes to meet the expense of the war. The other war taxes have been very generally abolished but the tax on the medical profession under the Harrison Narcotic Act remains. It is an unjust, iniquitous discrimination against the medical profession, and should be removed.

2. *The Tax on Traveling Expenses Necessary for Attendance at Meetings of Medical Societies.*—The Revenue Act of 1924, following the Revenue Act of 1921, authorizes the deduction of all ordinary and necessary expenses paid or incurred in carrying on any trade or business, before the computation of federal income taxes. It specifically authorizes the deduction of traveling expenses incurred in the pursuit of a trade or business. The Commissioner of Internal Revenue, however, denies the right of the physician to make any such deduction so far as relates to traveling expenses incurred in attending meetings of medical societies. The physician who attends a meeting of a medical society for the purpose of increasing his professional knowledge and skill is thus required by the Commissioner of Internal Revenue to pay a tax in order to avail himself of the opportunity to do so. This seems clearly contrary to public policy. It is not in keeping with the Commissioner's other interpretation of the law, which allows business men generally to deduct traveling expenses incurred in replenishing and enlarging their current business resources. It is nothing more or less than a tax on the knowledge and skill necessary for the prevention of disease and the relief and cure of suffering, injuries and illness.

3. *The Tax on the Expense of Postgraduate Study.*—The Revenue Act of 1924 authorizes the deduction of all ordinary and necessary expenses paid or incurred in carrying on any business or trade, which covers all ordinary and necessary expenses of the practice of medicine. The commissioner of Internal Revenue, however, has ruled that expenses of postgradaute study are not ordinary and necessary expenses incident to the practice of medicine, and are threefore not deductible. In effect, he requires the physician to pay a tax on the cost of postgraduate study and on the acquisition of knowledge and skill essential to his professional success. The tax seems clearly contrary to public policy. It is not in harmony with the practice allowed by law and recognized by the commissioner under which manufacturers and merchants are allowed to deduct as expenses of carrying on their business the cost of replenishing and extending their current business resources.

Copies of this letter are being sent to the President, to the Secretary of the Treasury and to each Senator and Representative of the State of Maryland.

J. A. CHATARD, Baltimore.
Secretary, Medical and Chirurgical Faculty of the State of Maryland.

APPLICATION FOR AFFILIATE FELLOWSHIP

Secretary West presented the application of Dr. William E. Edwards of Los Angeles for affiliate Fellowship in the American Medical Association, approved by the California Medical Society. The application was referred to the Council on Scientific Assembly.

REPORT OF REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BY-LAWS

Dr. E. L. Hunt, New York, Chairman of the Reference Committee on Amendments to the Constitution and By-Laws, then reported:

Your committee recommends the adoption of the following amendments to the Constitution:

1. Amend Section 3, Article 5, of the Constitution by substituting "175" for "150" in the second line, so that the first sentence in this Section shall read:

The total voting membership of the House of Delegates shall not exceed 175.

2. Amend Section 3, Chapter I, of the By-Laws, by substituting "1925" for "1903" in the second line, so that the first sentence of this Section shall read:

At the annual session of 1925, and every third year thereafter, the House of Delegates shall appoint a committee of five on reapportionment, of which the Speaker and the Secretary shall be members.

3. Amend Section 1, Article 6, of the Constitution, by inserting after the word "President" the words "President-Elect," so that the Section shall read:

The general officers of the Association shall be a President, a President-Elect, a Vice President, a Secretary, a Treasurer, a Speaker and a Vice Speaker of the House of Delegates, and nine Trustees.

4. We recommend that the amendment to Section 1, Chapter IV, of the By-Laws, be not adopted. This amendment reads as follows:

At some time between the first and fourth day of the Annual Session of the House of Delegates, the chairman and the secretaries of the various sections of the Scientific Assembly and the members of the Council on Scientific Assembly shall meet at the call of the chairman of the Council on Scientific Assembly and shall prepare and present to the House of Delegates, at their meeting on the fourth day of the annual session, three nominees for the office of President-Elect and two nominees for the office of Vice President, and the nominees so presented shall be the only ones eligible for election.

If this amendment were adopted, it seems to us that it would take away an important privilege and perogative of the House of Delegates. On the other hand, we appreciate the importance of the Section of the Scientific Assembly and suggest that the sections of the Scientific Assembly, if they so wish, send in an amendment by which they will have the power of making a certain number of nominees for the office of President-Elect and Vice President.

5. We recommend that Section 1, Chapter VI, of the By-Laws, be amended by substituting the third Friday in the month of February of each year for the first Friday in the month of February of each year, so that the regular annual meeting of the Board may in the future be held on the third Friday of February.

6. We recommend that Section 1, Chapter VI, of the By-Laws be amended to provide for the election of an Executive Committee by the Board of Trustees rather than for the appointment of such a committee by the chairman of the Board so that the first sentence of this section shall read as follows:

The Trustees, at their first meeting after the annual session of the House of Delegates, shall organize by electing a Chairman, a Secretary, and an Executive Committee of three members.

7. We recommend the establishment of a separate section to be known as the "Section on Radiology."

8. We recommend that the Section on Stomatology be abolished and that Section 1, Chapter XIV, of the By-Laws, be amended so that the sections after:

8. Pathology and Physiology

will read

9. Nervous and Mental Diseases
10. Dermatology and Syphilology
11. Preventive and Industrial Medicine and Public Health
12. Urology
13. Orthopedic Surgey
14. Gastro-Enterology and Protology
15. Radiology.
16. Miscellaneous Topics.

9. We recommend that Section 2, Chapter XIV, of the By-Laws, be amended by inserting after the seventh line in Section 2 the words:

If any vacancy occurs in the office of chairman, vice chairman or secretary of a section, such vacancy shall be filled by the election by the executive committee of such section of a Fellow who shall serve in the office indicated until the next annual session.

The section will then read as follows:

The officers of each section shall consist of a chairman, a vice chairman and a secrtary and such other officers as the section shall deem advisable. These shall serve for one year, or until their successors are elected and qualified; provided, that each section may elect its secretary to serve a longer time at its discretion. If any vacancy occurs in the office of chairman, vice chairman or secretary of a section, such vacancy shall be filled by the election by the executive committee of such section of a Fellow who shall serve in the office indicated until the next annual session.

The first amendment relating to Reapportionment of Delegates was approved by the Committee and the report of the Committee was adopted. This was an amendment to Section 3, Article 5 of the Constitution.

An amendment of Section 3, Chapter I, of the By-Laws was also approved by the Committee and adopted. An amendment of Section 1, Article 6, of the Constitution was approved by the committee and adopted.

The committee recommended that the proposed amendment to Section 1, Chapter IV, of the By-Laws be *not* adopted. The report of the committee was concurred in.

The committee's recommendation that the amendment to Section 1, Chapter VI, of the By-Laws be adopted was accepted. (This referred to changing the date of the annual meeting of the Board of Trustees.)

The amendment to Section 1, Chapter VI, of the By-Laws, providing for the election of an Executive Committee by the Board of Trustees, was adopted.

The Committee's proposed amendment to Section 1, Chapter XIV, of the By-Laws, establishing a Section on Radiology and abolishing the Section on Stomatology, was adopted.

The amendment to Section 2, Chapter XIV, of the By-Laws was adopted. Dr. Steiner, Connecticut, stated that this amendment should have been introduced by saying "The first part of the section will read as follows," because of more than one sentence to the section.

Dr. Hunt moved the adoption of the report as a whole. The motion was seconded by Dr. H. P. Linsz, West Virginia, and carried.

The Secretary, Dr. West, called the attention of the chairman of the Committee on Constitution and By-Laws to the fact that the adoption of the amendment to Section 1, Article 6, of the Constitution, making the President-Elect one of the general officers, will necessitate a change in Section 2 of the same article. This was referred to the chairman of the Reference Committee on Constitution and By-Laws to bring in a report to reconcile the inconsistency.

The session adjourned at 3:50 p. m. to reconvene at 9:30, Tuesday Morning.

(To be continued)

Ideas.—It is an extraordinary thing that all ideas in the mind exist in a perfectly chaotic, confused mass, until summoned into order by the attention. They are all struggling together in competition to get into the field of attention, they are all striving to cross the threshold and to reach the focus, or, as it has been also called, the dome of the mind. All ideas tend, if they can, to rise to the top of the dome, which they are more likely to do if they are linked up with some pleasurable feeling or an emotion, for we tend to retain happy thoughts and to cast out or to repress the opposite. Hence, the importance of cultivating the happy side of life, for happy suggestions tend to raise and exalt all the vital functions; they tend to quicken that inherent tendency to the normal which is characteristic of all living tissues; that disposition toward health or that equilibrium which doctors describe as the vis medicatrix naturae and which is always sensitive to suggestion, good or bad. It is a fact that once ideas get into the dome of the mind, or into the focus of consciousness, they become distinct and clear, because the attention or the will is fixed upon them; but even when within the dome they cannot be kept there, they soon pass out again to give place to other ideas, and it is stated that no group of ideas can remain in the focus of attention for more than thirty seconds. —Armstrong-Jones, Robert: Suggestion in Social Life, *Lancet* **1**:705 (April 4) 1925.

THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

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SATURDAY, MAY 30, 1925

SOME TRUTHS ABOUT ALCOHOL

Any one who attempts to arrive at an unbiased conclusion regarding the physiologic action of moderate amounts of alcohol on the human body realizes promptly that the decisive authentic information on the subject is surprisingly meager. There is no dispute about the ill effect of excessive indulgence in alcohol on individual and national efficiency; the habitual drunkard is a menace alike to himself and to the society that tolerates him. Yet many persons throughout the world, to whom the designation of drunkard could certainly not be applied with propriety, use alcoholic beverages moderately and secure therefrom not a little comfort and pleasure. It is a debatable question whether or not the enjoyment of the social glass must be proscribed because a large class misuse alcohol. The moderate users are frequently represented as those who "use" alcohol, as distinguished from those who "misuse" alcohol.

Physicians cannot avoid a consideration of the alcohol problem. It not only confronts them as it does every thinking person, but often is actually "thrust" on them by the exigencies of their daily routine. Probably the most debated feature centers in the inquiry as to whether alcohol can in any sense be regarded as a food. This is a question that demands a defensible answer regardless of the inquirer's personal habits, social proclivities or political convictions. Such a decision cannot be formulated on the basis of offhand impressions, hearsay evidence or subjective reasoning. It demands and deserves scientific analysis. Consequently, many persons will be interested in the statement of a physiologist having unusual qualifications for arriving at a conclusion when he asserts at length that the experimental evidence about the debated food value of alcohol "is extensive and admits of no controversy." Among the clearly proved facts that further study is not likely to modify to any degree, F. G. Benedict,[1] the director of the Boston Nutrition Laboratory of the Carnegie Institution of Washington, includes the observation that alcohol in not too large doses—that is, about 72 gm. daily—is oxidized in the human body, and the energy that it furnishes in its oxidation may contribute to keeping the body warm, to replacing other nutrients in the diet, and possibly to the performance of muscular work. Seventy-two grams of alcohol, contributing 500 calories to the daily ration, are more completely burned than 500 calories supplied in the form of almost any other substance, with the possible exception of pure sugar. This has been demonstrated clearly by actual measurements of the heat output of man inside a respiration calorimeter, first, when subsisting on an ordinary diet, not containing alcohol, and then under exactly the same experimental conditions when 500 calories of fat or carbohydrate, or both, were replaced by 500 calories of alcohol.

This interpretation of alcohol as a food is, then, based on the demonstration that it can replace fat and carbohydrate in no small measure in the diet. Benedict hastens to remind us, however, that there are two functions of food that probably cannot be filled by alcohol. It is highly improbable that alcohol becomes a part of organized tissue, and its exact function in the energy required for the performance of muscular work is by no means clear. We know, Benedict adds, that fat, carbohydrate and protein do become a part of organized tissue, and do contribute to the performance of muscular work.

Viewed in the foregoing light, it might seem as if alcohol, being a food, should be physiologically permissible, if used in moderation. In attempting to meet the crux of the situation by determining the physiologically "permissible" amount for daily use, science has also recently indicated that something more than the danger of incipient intoxication must be taken into account. All the more recent psychologic tests with alcohol ingested even in small amounts agree in the demonstration of lessened organic efficiency resulting from the absorption of the substance.[2] From two to four hours after moderate doses of alcohol, practically all persons are affected with general depression of neuromuscular processes, lessened visual acuity, and lessened motor coordinations of eye and hand. Benedict argues that in assessing the value of alcoholic beverages for the use of mankind, the true scientist may not disregard the obviously beneficial and seemingly legitimate phases of its effect on man. He must give recognition to the fact that, used in moderation, besides being an easily digestible source of calories, it results in a great deal of gratification and pleasure to enormous numbers of people, giving them relaxation at times and again, by releasing the inhibitions, a stimulus. Nevertheless, it seems certain

1. Benedict, F. G.: Alcohol and Human Physiology, Indust. & Engin. Chem. 17: 423 (April) 1925.

2. Miles, W. R.: Pub. 266, Carnegie Institution of Washington, 1918; Pub. 333, 1924.

that at any time when one is confronted with a task that calls for a clear head, a keen vision and a steady muscle, there is no "permissible" dose of alcohol.

ACID FRUITS

Among the more recent contributions of the science of nutrition to our understanding of the rôle of foods has been a better appreciation of what constitutes acid and alkaline conditions in the body. There are not a few dietary substances, notably certain fruits, that are demonstrably acid as examined in the chemical laboratory. At a time when so-called "acid conditions" were greatly dreaded as a possible pathologic entity in the organism, physicians were wont to proscribe the use of such acid foods for susceptible patients. This was particularly true during the period, a quarter of a century and more ago, when the much discussed uric acid diathesis became a clinical bugaboo as forbidding as it was misunderstood. The laity quickly acquired an interest in the mysterious condition that portended "too much acid" in the organism. Sometimes this actually resulted in a sitophobia, so far as acid foods were concerned.

The substances responsible for most of the evident acidity of certain fruits and vegetables are acid salts of organic acids, in part volatile but mostly fixed in character. Citric, malic, succinic and tartaric acids belong in this category. The last are only partly burned up in the organism and consequently can function as acids in the metabolism. The fate of other organic acids may be quite different. Thus, when the acid potassium citrate of oranges is absorbed into the system, its citric acid is burned, leaving potassium carbonate in its place, and this potassium carbonate acts to increase the reserve alkalinity of the body fluids. Blatherwick and Long found that drinking even large amounts of orange juice always resulted in the production of alkaline urine. "It was impossible to overreach the organism's ability to oxidize the contained citric acid," even though the amount drunk were the equivalent of twenty-four large oranges eaten daily. Consequently, it has become customary to speak of some of the acid foods as potentially alkaline in metabolism; just as proteins that yield sulphuric and phosphoric acids from the oxidation of their organic sulphur and phosphorus complexes are potentially acid in their function for the acid-base adjustments of the body.

It has been observed that some of the organic acids that resist ready oxidative disintegration in the organism tend, when introduced in large quantities, to exert a nephropathic action. The so-called experimental tartrate nephritis is a familiar illustration. Benzoic acid, which occurs in certain fruits, becomes detoxicated by conversion to the innocuous hippuric acid, which, nevertheless, functions as an acid component. Consequently, it is highly desirable to learn in detail the facts regarding the organic acids that we ordinarily consume in the diet; and this is especially true in view of the confusion that still exists with regard to various food materials. At the Bureau of Chemistry, Nelson [1] recently made a painstaking study of several familiar items. It showed that the nonvolatile acids of the strawberry are citric acid (about 90 per cent.) and *l*-malic acid (about 10 per cent.), and that the pineapple acids are citric acid (about 87 per cent.) and *l*-malic acid (about 13 per cent.); that in the red raspberry the acids are a mixture of citric acid (about 97 per cent.) with *l*-malic acid (about 3 per cent.), and in the black raspberry the acid is citric acid. The acids of the Concord grape are a mixture of *l*-malic acid (about 60 per cent.) and *d*-tartaric acid (about 40 per cent.). With the readily oxidized citric acid—the familiar component of the potentially alkaline citrus fruits—so predominant in the edible berries, we may safely dismiss much of the prejudice that their acid reaction has unjustly directed to them. Sherman [2] has even paid a tribute to the group in suggesting that the benefit to health which so generally results from a free use of milk, vegetables and fruits in the diet may be attributable in part to the fact that these foods yield alkaline residues when oxidized in the body; but this point, Sherman adds, should not be too greatly emphasized, for there are several other respects in which the eating of liberal amounts of milk, vegetables and fruits is certainly beneficial, notably in supplying calcium, iron and vitamins, and in improving the intestinal conditions.

PARTURITION

Parturition is a complex act, which still is confessedly obscure in its genesis and execution. An organ, the uterus, that has been quiescent or at most feebly active despite the profound changes that are going on within it during pregnancy, presently starts to exhibit contractile reactions of a vigorous character. The hypothesis that the fairly sudden onset of labor pains is due solely to mechanical distention of the uterus has never found hearty acceptance, though some writers have championed the view. Others have assumed degenerative changes in the placenta as the exciting cause; or, again, the initial stimulus has been alleged to come from the fetus. As a recent student of the subject has remarked, no doubt the fetus itself acts as a direct stimulus, and without the fetus the intense muscular contractions would not occur; but it seems equally clear that the onset of labor cannot easily be accounted for without postulating some further exciting cause apart from the fetus and uterus.

In contemplating "long distance" influences on the gravid uterus, one naturally considers stimuli that may

1. Nelson, E. K.: The Nonvolatile Acids of the Strawberry, the Pineapple, the Raspberry and the Concord Grape, J. Am. Chem. Soc. **47**: 1177 (April) 1925.
2. Sherman, H. C.: Chemistry of Food and Nutrition, New York, the Macmillan Company, 1918, p. 282.

be carried to it by nervous paths from the central nervous system, either directly or through reflex arcs. However, it has been shown that delivery may occur when the nerves connecting the uterus with such centers are severed, so that the act is essentially an independent function of this organ. This does not negate the possibility that the contractions of the uterus may be influenced by reflex effects through its extrinsic nerves; but the facts now available tend to focus attention on the probability that in parturition hormones play a more important part than do nervous impulses from without.

Experimentally, it is a well established observation that extracts of the pituitary and also the secretion of this structure exert a marked oxytocic effect—producing uterine contractions by direct action on the muscle walls. This fact is already receiving recognition in the domain of therapy when pituitary preparations are used to expedite parturition.[1] But as the latter act occurs only at definite periods, the question arises as to why the pituitary should become activated at such a time. An answer has recently been offered by Dixon and Marshall,[2] on the basis of animal experimentation. They believe that ordinarily the cause of birth is a function of a certain stage in the ovarian rhythm. There is no evidence that the ovarian secretion brings about parturition by acting directly on the muscles of the uterus. However, the secretion of the ovary in the absence of fully formed (and therefore presumably functional) corpora lutea has a definite specific stimulating effect in promoting pituitary secretion. The secretion of the ovary in the presence of such corpora lutea, on the other hand, has no such effect, its action on the pituitary gland being completely negative.

The new studies of these British workers support the view, to quote their own interpretation, that in the presence of fully formed and presumably functional corpora lutea, the normal ovarian secretion is largely or entirely in abeyance, and this is the condition more particularly during pregnancy. In other words, the corpus luteum may be supposed so to dominate the ovarian metabolism at these periods that the ovarian secretion, which at other times activates the pituitary, is inhibited or else is neutralized by the secretion coming from the corpus luteum. At the close of pregnancy, when the corpora lutea are in an advanced stage of involution, the normal secretory activity is once more produced, and the pituitary is excited to secrete in greater quantity. When the threshold stimulus of the pituitary secretion on the uterus is reached and passed, the pains of labor set in and parturition results. The growing irritability of the uterus in the later stages of pregnancy is explained as functionally correlated with the involution of the corpus luteum.

A bearing of such a view on both ovarian and pituitary therapy will at once suggest itself. We are reminded thereby that in the preparation of the ovarian products it may be of the utmost importance that account should be taken of the stages of pregnancy, or of the estrual cycle, of the animals from which the ovaries are obtained for the purpose of manufacturing extracts. Moreover, as Dixon and Marshall point out, it is not sufficient merely to discriminate between ovaries which contain corpora lutea and those which do not, since in the closing stages of pregnancy when the corpora lutea are in a condition of advanced involution, they are still of considerable size, and superficially and macroscopically are similar to corpora lutea at an earlier stage of pregnancy, when they may be presumed to be in a state of full functional activity. The advice is given, therefore, that due account should be taken of the precise condition of the animals from which ovaries are obtained in regard to the occurrence of ovulation, estruation and pregnancy, before such glands are utilized for making extracts. Perhaps if such considerations are carefully followed in the future, the outlook on ovarian therapy will be less dubious; at present, critical students of the subject still insist that "rational as ovarian therapy appears to be in some conditions, the results are rarely striking and often nil to the level-headed observer."[4]

Current Comment

ACTINOTHERAPY

In a recent issue of THE JOURNAL,[5] reference was made to the recent rapidly developing elucidation of some of the effects of light on foods and nutrition. These influences, whether exerted directly on the body or through the irradiation of extraneous substances, are associated with rays having a shorter wave length than those of the visible portion of the spectrum. Rays longer than about 313 millimicrons seem to have no effect in rickets; hence, the therapeutic potency of sunlight in this disease at least is probably due to the ultraviolet rays. Hess has pointed out that the longer, visible waves may exert a counteracting force on the action of the ultraviolet rays, so that when visible and invisible radiations impinge at the same time on the skin, the power of the ultraviolet rays is somewhat lessened. This counteracting or inhibiting action does not, however, seem to be of great magnitude. With the demonstration of a sound scientific basis for heliotherapy as well as actinotherapy with artificially generated radiations, notably as they apply to the treatment or prevention of rickets, new hopes were placed in the efficacy of sunlight. The advocacy of the outdoor life has received a great impetus, and we shall hear much about sunshine and health in the

1. Glandular Therapy, Chicago, American Medical Association, 1925, p. 57.
2. Dixon, W. E., and Marshall, F. H. A.: The Influence of the Ovary on Pituitary Secretion: A Probable Factor in Parturition, J. Physiol. 59: 276 (Dec. 23) 1924.
4. Glandular Therapy, p. 87.
5. Light and Nutrition, editorial, J. A. M. A. 84: 1574 (May 23) 1925.

coming months. Unfortunately, there is likely to be some disappointment. Hess [6] has uttered a timely warning based on a study of sunshine in different parts of the world. A comparison of the yearly amount of sunshine in cities in the temperate zone demonstrates that there is no close parallelism between the incidence of rickets and annual sunshine. It shows, furthermore, that the occurrence of rickets does not depend on an equable distribution of sunshine throughout the year. The determining factor, Hess points out, is the quality, not the quantity, of the sun's rays—the amount and intensity of those short ultraviolet radiations which alone are of value in preventing rickets. The results of heliotherapy during the winter months have been disappointing, owing to the fact that the "antirachitic region of the solar spectrum" is greatly limited at this season and that the infants cannot be exposed directly to the rays on account of the severity of the climate. It would seem that the amount of the effective solar radiations is so small in the winter that even if we substitute quartz panes for ordinary window glass, it will be insufficient to afford protection and eradicate rickets. It is in view of this unpromising report that physicians should be prepared, where advisable, to counsel supplementing nature's niggardly sunshine with the results of man's discoveries. It should no longer be difficult to protect children from rickets; and as antirachitic action consists in the induction of calcium assimilation and its conservation, this is a matter that concerns not only the young but also the adult, particularly when large physiologic demands are made on the latter in pregnancy and lactation.

PROSECUTION OF MEDICAL FRAUDS IN CALIFORNIA

California has for many years been reputed a happy hunting ground for medical impostors and quacks. Fortunately, however, and particularly during the last seven years, the board of medical examiners has conducted a thorough and continuous campaign against pseudodoctors. The prosecutions have been quite successful in spite of a complicated medical practice act which legalized several different varieties of medical practitioners. From no other state during the last six or seven years have so many reports been received regarding the prosecution of illegal practitioners and the revocation of the licenses of physicians found guilty of criminal or illegal practice. In few states have such careful records been kept of those engaged in the various branches of the healing art. The disclosure, two years ago, of the Missouri diploma-mill ring has resulted in thorough investigations of loose or illegal methods of medical licensure in several states. This investigation began in Connecticut, since that was the state having a wide-open door where low-grade doctors found easy entry to the practice of medicine. Taking advantage of the evidence regarding diploma purchasers brought out by this investigation, the California board continued further to purge that state of a score or more of other medical impostors, and the licenses of several notorious persons have been revoked. Heretofore the board has received adequate financial support to carry the prosecution to a sufficient end. Recently, members of the diploma mills were dismissed on motion of the prosecution because the authorities of San Francisco failed to provide sufficient funds to prosecute the cases. Thus the efforts made by the California board to prevent preying on the public have been stopped for the need of sufficient funds. It is hoped that not only the city of San Francisco but also the state of California will see to it that money is provided to sustain the one barrier between ignorant and incompetent pretenders and the sick or injured people of that state.

6. Hess, A. F.: The Ultraviolet Rays of the Sun, J. A. M. A. 84: 1033 (April 4) 1925.

Medical News

(PHYSICIANS WILL CONFER A FAVOR BY SENDING FOR THIS DEPARTMENT ITEMS OF NEWS OF MORE OR LESS GENERAL INTEREST: SUCH AS RELATE TO SOCIETY ACTIVITIES, NEW HOSPITALS, EDUCATION, PUBLIC HEALTH, ETC.)

ARKANSAS

Fraudulent "Accidents."—Emanuel Gartman, Doniphan, Mo., pleaded guilty, May 14, in the U. S. District Court, Little Rock, to a charge of using the mails to defraud, and was sentenced to two years in the federal penitentiary at Atlanta, it is reported. Gartman, who is alleged to be head of a group, was charged with conspiring to defraud insurance companies in which he held policies covering injuries due to automobile accidents. He is said to have arranged to receive half of certain sums which insurance companies paid to settle claims for accidents. The government charged that he injected some substance subcutaneously to cause disfiguration like that of an injury. Gartman and seven of the alleged group, it is reported, are under indictment in the federal court in Cape Girardeau on similar charges. Those indicted with him, all of whom live near Doniphan, are reported to be John Williams, Olean Elrod, Barney Ray, Thomas B. Little, Newton Creach, Carl Pickett and Cleveland Doyle.

Health Officers Appointed.—The state board of health at a meeting, May 11, approved the appointment of health officers for counties, as follows, it is reported:

County	*Physician*
Ashley	B. F. George, Hamburg.
Baxter	J. J. Morrow, Cotter.
Benton	C. A. Rice, Rogers.
Boone	J. J. Johnson, Harrison.
Carroll	A. L. Carter, Berryville.
Chicot	B. C. Clark, Lake Village.
Clark	H. A. Ross, Arkadelphia.
Clay	M. Outlaw, Rector.
Columbia	J. J. Baker, Magnolia.
Craighead	J. T. Altman, Jonesboro.
Crawford	J. E. Blakemore, Van Buren.
Crittenden	H. S. Watson, Earle.
Cross	J. D. McKie, Wynne.
Dallas	H. H. Atkinson, Fordyce.
Faulkner	J. S. Westerfield, Conway.
Franklin	Thomas Douglass, Ozark.
Fulton	E. L. Garner, Mammoth Spring.
Garland	B. F. Casada, Hot Springs National Park.
Greene	E. S. Baker, Paragould.
Hot Springs	W. G. Hodges, Malvern.
Howard	B. S. Stokes, Center Point.
Independence	W. B. Lawrence, Batesville.
Johnson	W. R. Hunt, Sr., Clarksville.
Lafayette	F. E. Baker, Stamps.
Lee	O. L. Williamson, Marianna.
Logan	L. H. Jewell, Paris.
Lonoke	J. R. Cunning, Lonoke.
Marion	L. M. Weast, Yellville.
Mississippi	W. S. McCall, Blytheville.
Monroe	P. E. Thomas, Clarendon.
Montgomery	W. D. Freeman, Mount Ida.
Ouachita	W. A. Purifoy, Chidester.
Perry	W. L. Rieff, Perryville.
Phillips	W. B. Bruce, Marvell.
Poinsett	J. W. Elders, Harrisburg.
Pope	James F. Hays, Russellville.
Prairie	J. C. Gilliam, Des Arc.
Pulaski	V. T. Webb, Little Rock.
Saline	J. W. Walton, Benton.
Scott	L. D. Duncan, Waldron.
Sharp	William Johnston, Hardy.
St. Francis	P. P. Boggan, Forrest City.
Stone	W. W. Carnett, Mountain View.
Union	Fergus O. Mahony, El Dorado.
Washington	J. W. Walker, Fayetteville.
White	J. R. Runyan, Searcy.
Woodruff	R. N. Smith, Augusta.
Yell	T. J. Pool, Danville.

CALIFORNIA

Selling Degrees a Felony.—The medical practice act of California has been amended, making it a felony to sell or barter a medical degree or document used in connection with the practice of medicine, or to impersonate another in an examination or claim falsely to be licensed to practice in

the state. The penalty for conviction is not less than a $1,000 fine or one year imprisonment.

"Poor Whittier."—Recently Simon J. Murphy, Jr., Pasadena, donated a hospital costing more than $325,000 to the city of Whittier as a memorial to his parents on condition that only accredited physicians should be admitted to the staff (THE JOURNAL, June 28, 1924, p. 2124). Attracted by the beauty and equipment of the hospital, the osteopaths and chiropractors in that community agitated until they forced a referendum vote of the citizens of Whittier which favored admitting these cultists to the hospital staff. The board of trustees and the staff of the hospital, in protest, then resigned. Mr. Murphy demands now that the city live up to its original agreement or refund $325,000. In a letter to the trustees of Whittier, he stated that the ordinance allowing practitioners of all kinds to use the hospital is in direct violation of the state law, and although passed by referendum, it became a law only because the citizens had been misinformed as to the nature of the hospital endowment.

GEORGIA

Personal.—Dr. Thomas D. Coleman, Augusta, a former president of the Medical Association of Georgia, has been appointed a colonel in the Medical Officers' Reserve Corps. ——Dr. Joseph D. Applewhite, Athens, has been appointed to assist in the selection of a site and to supervise the construction of the tuberculosis hospital for Clarke County.—— Dr. Leonard A. Baker, Tifton, has been appointed by the governor a member of the state board of medical examiners.

ILLINOIS

State Medical Election.—Dr. Mather Pfeiffenberger, Alton, was elected president-elect at the seventy-fifth annual meeting of the Illinois State Medical Society, Quincy, May 21; Drs. Warren F. Pearce, Quincy, and John J. Pflock, Chicago, vice presidents; Dr. A. J. Markley, Belvidere, treasurer, and Dr. Harold M. Camp, Monmouth, secretary. Dr. Jacob C. Krafft, Chicago, was installed as president.

Banquet to Dr. Lewis.—More than 100 physicians attended the banquet of the Henry County Medical Society, Kewanee, May 12, in honor of Dr. Dean Lewis, Chicago. Dr. Lewis addressed the society on "Bone Tumors"; Dr. Charles A. Elliott, Chicago, spoke on "Chronic Cholecystitis," and Dr. Allen B. Kanavel, Chicago, on "Differential Diagnosis of Appendicitis, Peptic Ulcer and Gallbladder Disease." The society presented Dr. Lewis with a traveling bag.

Chicago

President Burton Is Dead.—Ernest DeWitt Burton, president of the University of Chicago, died, May 26, of complications following an operation for cancer of the intestine. Dr. Burton has been associated with the faculty of the University of Chicago since its establishment in 1892.

Alumni and Faculty Banquet.—The joint banquet of the faculty and alumni of Rush Medical College of the University of Chicago, will be held, June 16, at the Auditorium Hotel at 7 p. m., tickets $2 per cover, and the alumni meeting at the same place at 5:30 p. m. The silver anniversary of the class of 1900 will be celebrated by a class dinner at the Sherman House at 6:30 p. m. There will be a "great one day rally" of the alumni of the University of Chicago, June 13.

Gifts to the University of Chicago.—Gifts of $428,000 to the University of Chicago's development fund were announced, May 19, bringing the total to date to $6,384,596. The largest gift announced on that date was $200,000 by Charles H. Swift, to endow one of the distinguished service professorships, and a gift of $100,000 by Max Epstein, to be used at the discretion of the trustees for scientific work in medicine or one of the allied sciences. This is in addition to the dispensary, a gift from Mr. Epstein previously announced.

Report of Committee on Baby Congress.—At the first National Baby Congress and Health Exposition, at the American Exposition Palace, Chicago, held under the auspices of the Illinois State Medical Society, there were about 13,500 registrations. More than 8,000 physical examinations were made in the nine days of the congress. There were 864 examiners, including psychiatrists, pediatricians, general practitioners, eye, ear, nose and throat specialists, genitourinary specialists and dentists, sixty nurses, twelve scorers, and many other assistants. There were entrants from more than twelve states. While the medical profession was in charge of the congress, it received support from the Red Cross, the Illinois Tuberculosis Association, the state and city health departments, the South Park Board, the Sanitary District of Chicago, the Illinois Federation of Women's Clubs, the Boy Scouts, the Girl Scouts and many lay organizations.

INDIANA

State Board Election.—Dr. John H. Green, North Vernon, has been elected president of the state board of health to succeed Dr. Hugh A. Cowing of Muncie, and Dr. Thomas B. Victor Keene, Indianapolis, vice president.

Dr. Royse Reinstated.—Dr. James G. Royse, Indianapolis, who several weeks ago was relieved of his duties as assistant secretary of the state board of health, was reinstated, May 18, it is reported, following a hearing of his case by the board.

No Trachoma Found.—Dr. Paul D. Mossmann, U. S. Public Health Service, in charge of trachoma work with headquarters at Louisville, Ky., recently examined a total of 100 suspected cases of trachoma in school children at French Lick, West Baden and Bedford. None of the suspects were found to have trachoma.

LOUISIANA

Conference of Health Officers.—The state board of health announces a three day conference in New Orleans of the health officers of the state, beginning June 15.

Personal.—Dr. Edward S. Kelly, New Orleans, has been appointed state food and drug commissioner and Dr. Joseph E. Doussan, Lutcher, registrar of vital statistics, vice Dr. J. George Dempsey, New Orleans.

MARYLAND

Florence Nightingale Relics.—National Hospital Day (May 12) was observed at the Johns Hopkins Hospital, Baltimore, by the display of a collection of Florence Nightingale relics, including a half dozen letters and the wheel chair used after her health failed following the Crimean War.

Review Courses for Physicians.—The Division of Medical Extension, University of Maryland, offers a series of courses to the physicians of the state, to be held from June 1 to June 27. They are planned as a review of fundamental data in special fields and of recent advances in diagnosis and treatment. Each class will meet daily for two to three hours. There will be demonstrations and practice in diagnostic procedures. There will be daily clinics from 11:30 to 12:30 in medicine, surgery and the specialties, which are not a part of the course, but are open to all registered physicians. The number of registrants for each course will be limited, and only two courses may be pursued at one time.

MASSACHUSETTS

Committee to Conduct Cancer Investigation.—In accordance with a resolution of the last legislature to conduct an investigation into the prevalence of cancer and the facilities for the care of cancer patients in Massachusetts, Drs. George H. Bigelow and Merrill E. Champion, representing the department of public health, and Dr. John H. Nichols and Frank W. Goodhue, representing the department of public welfare, have been appointed to conduct the investigation. The committee has engaged Dr. Herbert L. Lombard, formerly health officer in Aroostook County, Me., to act as field agent.

State Medical Meeting.—The one hundred and forty-fourth annual meeting of the Massachusetts Medical Society will be in the John Hancock Mutual Life Insurance Company Building, 197 Clarendon Street, Boston, June 9-10. Addresses will be given by Dr. Francis G. Blake, New Haven, on "The Treatment of Scarlet Fever with Antitoxin"; Dr. Cole B. Gibson, Meriden, Conn., on "The Diagnosis and Treatment of Juvenile Tuberculosis," and Dr. Oswald S. Lowsley, New York, on "Major Urological Operations Under Regional Anesthesia." The annual dinner will be at the Copley-Plaza, Wednesday, and the annual discourse will be given at noon, Wednesday, by Dr. David Cheever, on "The Physician as Custodian of the Health of the People but Who Shall Guard the Custodian Himself?" There will be clinics at the Peter Bent Brigham, Massachusetts General and Boston City hospitals, and a round table conference at the Boston Lying-In Hospital at 3 p. m., Tuesday.

MICHIGAN

Detroit Alumni Annual Clinic.—The Alumni Association of the Detroit College of Medicine and Surgery will hold its annual clinic beginning June 15. There will be a daily program participated in by staffs of five of the leading hospitals, assisted by Dr. M. Rackemann, Boston, who will give a clinic on "Asthma and Hay-Fever"; Dr. Roger S. Morris, Cincinnati, on "Diagnosis of Pericarditis" and "Clinical Diagnosis of Cardiac Arrhythmias"; Dr. Barton C. Hirst, Philadelphia, gynecology; Dr. John B. Deaver, Philadelphia, surgery, and Dr. Bentley Squier, New York, urology. Dr. Deaver will address the graduating class.

MISSOURI

State Board Appointments.—Governor Baker has reappointed Drs. James R. McVay, Kansas City, Homer L. Kerr, Crane, James Stewart, St. Louis, and Cortez F. Enloe, Jefferson City, as members of the state board of health, whose terms will expire April 18, 1929. Dr. Stewart is both secretary of the board and state health commissioner, with headquarters at Jefferson City.

Physicians Fined.—Dr. William H. Burton, Vanduser, was fined $500 in federal court at Cape Girardeau, recently, it is reported, after pleading guilty to a charge of failing to keep proper records of the prescribing and sale of narcotics, and Dr. Abraham L. Stepp, Sikeston, indicted last year on a charge of violating the Harrison Narcotic Law, was fined $500, after pleading guilty to a charge of failing to keep sufficient records.

Dr. Brooks Goes to Vanderbilt University.—Dr. Barney Brooks, associate professor of clinical surgery, Washington University School of Medicine, St. Louis, has accepted the offer to become head of the department of surgery of Vanderbilt University Medical Department, Nashville, Tenn., and will take up his new work in the fall. Dr. Brooks is the second member of the faculty of Washington University Medical School to go to Vanderbilt, Dr. G. Canby Robinson, dean of Vanderbilt, being the other.

MONTANA

State Medical Meeting.—The Medical Association of Montana will hold its annual meeting at Lewistown, July 8-9. The Montana Public Health Association will meet July 6-7, as will also the state board of health, state tuberculosis association, and other groups in which both laymen and physicians take part. Among the speakers will be Dr. Floyd S. Clarke, professor of pediatrics, University of Nebraska School of Medicine, Omaha; Dr. William C. Woodward, secretary of the Bureau of Legal Medicine and Legislation of the American Medical Association, Chicago, and Dr. John deJ. Pemberton, Rochester, Minn.

NEBRASKA

State Medical Election.—At the annual meeting of the Nebraska State Medical Association, Lincoln, May 14, Dr. Henry J. Lehnhoff, Lincoln, was elected president and Drs. Porter F. Dodson, Wilber, and Ernest O. Weber, Wahoo, vice presidents. Dr. Roy B. Adams, Lincoln, was elected secretary and treasurer a year ago for a term of three years.

NEW JERSEY

Illegal Practitioners Fined.—It is reported that Joseph N. Voza, Jersey City, a chiropractor, was found guilty, April 26, of practicing medicine without a license in the first district court and fined $200. The trials of chiropractors, John H. Conover, Union Hill, and Louis H. Conway, Jersey City, were deferred until May 26. Daniel W. Cusuck, a naturopath of Jersey City, was also fined $200 for practicing medicine without a license.

NEW YORK

Contributions for Prevention of Blindness.—At the semiannual meeting of the board of directors of the National Committee for the Prevention of Blindness, an anonymous contribution of $6,000 was announced. It was also announced that contributions ranging from 25 cents to $1,000 had been made by 10,052 persons.

State Medical Election.—At the one hundred and nineteenth annual meeting of the Medical Society of the State of New York, Dr. Nathan B. van Etten, New York, was elected president; Drs. W. H. Ross, Long Island, and Frederick H. Flaherty, Syracuse, vice presidents; Dr. Daniel S. Dougherty, New York, secretary; Dr. H. G. Myers, New York, assistant secretary, and Dr. Charles G. Heyd, New York, treasurer (reelected).

Medical Work in Industry.—A survey of the cost of health service in industry now being made by the National Industry Conference Board shows that on an average about 16 per cent. more money per employee is being expended by industry on medical supervision than was being spent four years ago, when a similar survey was made. Out of 446 establishments covered by the survey, 255 report that applicants for employment are given physical examinations, and most of these plants are guided by the result of the medical examination in selecting work for the applicant.

New School of Medicine and Dentistry.—The new School of Medicine and Dentistry of the University of Rochester will register students, Sept. 25, 1925. Plans have been made to enroll seventy-five in the future, fifty of whom will be medical students and twenty-five dental students, but the September class will be limited to twenty-five. Clinical facilities will be provided by the union of the Strong Memorial Hospital and the Municipal Hospital, making a total of 440 beds. Instruction in dentistry will cover four years, dental students being admitted on the same terms as medical students. The faculty is composed of Dr. George Hoyt Whipple, dean and professor of pathology; Dr. George Washington Corner, professor of anatomy; Walter Ray Bloor, Ph.D., professor of biochemistry and associate dean; Dr. Stanhope Bayne-Jones, professor of bacteriology; Dr. William Sharp McCann, professor of medicine; Dr. Karl Miller Wilson, professor of obstetrics and gynecology; Dr. John J. Morton, Jr., professor of surgery; Dr. Samuel Wolcott Clausen, professor of pediatrics; Wallace Osgood Fenn, Ph.D., professor of physiology, and various other assistant professors and instructors.

New York City

Child Psychology Library.—The Alice Morgenthau Erich Memorial Library of several thousand volumes on child psychology was dedicated at 242 West Seventy-Sixth Street, May 13. Judge Mack of the federal court was the principal speaker.

Academy Building Sold.—The building of the New York Academy of Medicine on West Forty-Third Street has been sold to James T. Lee. Possession will be given in two years, when the academy will be occupying its new home on Fifth Avenue.

Funds to Prevent Smallpox.—Health Commissioner Monaghan obtained an emergency appropriation of $80,000, May 15, to prevent the spread of smallpox in the city. At that time there were six cases. Dr. Monaghan proposed an educational campaign to inform the public of the necessity of vaccination and to establish free vaccination depots to accommodate persons who applied.

Report of Henry Street Settlement.—According to the annual report of the settlement, 8,993 babies were cared for during 1924, of which only 107 died. More than 400,000 calls were made by the visiting nurses, and 15,126 patients were ministered to, including 10,025 children from 1 to 14 years of age. During the year, 229 student nurses were trained and a special effort was made to carry the public health nursing service into negro districts.

Plans for Municipal Hospitals.—The mayor has approved plans for the Bronx General Hospital to be erected between One Hundred and Sixty-Seventh and One Hundred and Sixty-Eighth streets and Walton and Girard avenues, at an estimated cost of about $3,500,000, of which the city has provided already $2,000,000. The main building will be nine stories high, with 322 beds.——The city is planning to purchase twenty-six lots on Jackson Avenue, between One Hundred and Forty-Fifth and One Hundred and Forty-Seventh streets as the first step in the erection of a $1,200,000 hospital. When completed this institution may replace the Lincoln Hospital.

Hospital News.—Plans have been completed for a fifteen story nurses' home for Mount Sinai Hospital, New York, to be erected at a cost of $1,000,000.——A tuberculosis clinic service will be established at Kings County Hospital, Brooklyn, for more efficient care of the 2,200 known tuberculosis cases in that area.——A new 100 bed structure, costing $200,000, will be built for the Caledonian Hospital. The present building will be used as a nurses' home.——The laying of the cornerstone of the New Sydenham Hospital, Manhattan Avenue and One Hundred and Twenty-Third Street, took place, May 17, at 3 p. m., with appropriate

ceremonies.——A third negro clinic was opened, May 7, at One Hundred and Thirty-Sixth Street by the Maternity Center Association.——Two windows and a bronze tablet were unveiled by soldiers at Governors Island, May 7, in the garrison chapel, to the memory of Mrs. Lamount, founder of the Army Relief Society and for seventeen years its national president.——The present home of the Brooklyn Eye and Ear Hospital has been sold to William A. White for presentation by him to the Polytechnic Institute. The hospital will erect a new building at a cost of $1,500,000.——The fortieth anniversary of Montefiore Hospital for Chronic Diseases was celebrated, April 5. George E. Vincent, Ph.D., president, Rockefeller Foundation, spoke on "The Hospital and the Community." It was stated that the directors had pledged $450,000 toward modernizing the Bedford Hills Tuberculosis Sanatorium conducted by the hospital.

NORTH CAROLINA

Defective Children.—At the forty-ninth annual session of the American Association for the Study of the Feeble-Minded, Raleigh, May 9, Dr. Charles B. McNairy, superintendent, North Carolina State School for Feeble-Minded, Kinston, presented a study of this state's defectives, placing the number of feebleminded children at about 8,000. Of this number, the state institution is caring for 370 at Caswell Training School, but from forty to fifty of them will be returned to their homes or communities, the recent legislative session having failed to make appropriations sufficient to provide food for that number. The state school has building accommodations for 500 inmates. It is reported that the council of state will be importuned to make special provision whereby those already in the school can be retained despite the lacking appropriations for maintenance.

OHIO

Chiropractor Held for Manslaughter.—R. S. Odier, an unlicensed chiropractor at Rittman, was arraigned, May 11, on a charge of manslaughter following the death of Irene Blough, aged 3, from diphtheria. It is reported that Odier gave the child a chiropractic treatment on the day before her death.

University President Retires.—William O. Thompson, president of Ohio State University, Columbus, since 1899, will retire from active service on his seventieth birthday. The board of trustees, after accepting Dr. Thompson's resignation, effective November 5, voted to make him president emeritus of the university.

Ruling on Joint Hospitals.—On request from Ashtabula County, where the city of Ashtabula and the trustees of Ashtabula Township have considered establishing a joint hospital for contagious disease, the attorney general rendered an opinion which held that a municipality and a township cannot join in the erection and maintenance of a hospital for contagious diseases. This is in harmony with opinions by Ohio attorney generals in 1916 and 1918.

OKLAHOMA

State Medical Election.—At the annual meeting of the Oklahoma State Medical Association, Tulsa, May 12-14, Dr. Arthur S. Risser, Blackwell, was elected president-elect and Drs. Samuel E. Mitchell, Muskogee, Joseph S. Fulton, Atoka, and Robert S. Love, Oklahoma City, vice presidents. The next annual meeting will be at Oklahoma City in May, 1926.

PENNSYLVANIA

Personal.—Dr. Charles L. Summers, Baltimore, addressed the Lancaster City and County Medical Society, May 6, on "Infantile Diarrheas and Their Management."——Dr. H. C. Cassidy, May 5, was appointed chief surgeon of the Lewistown Hospital, following the retirement of Dr. Fred W. Black.——Dr. Louis F. Arensburg, East Millsboro, who is in his eighty-third year, continues to be an active member of the Fayette County Medical Society. Dr. Arensburg served in the War of the Rebellion and is now National Commander of the Grand Army of the Republic.——Dr. William H. Mayer, Pittsburgh, has been elected president-elect of the Allegheny County Medical Society, and Dr. Alexander H. Colwell, Pittsburgh, secretary.

"National Medical Clinic" at Newcastle.—About six weeks ago the "National Medical Clinic" began operating in Newcastle, and, May 2, it is reported, two of its "doctors" were in jail. "Dr." J. J. Mazur, said to be a chiropractor and an osteopath, was arrested on a charge of assault and battery and for practicing medicine without a license, and he and "Dr." Charles A. Duff and Dr. Dinsmore D. Delaney on a charge of conspiracy. In explaining his connection with the "clinic," Dr. Delaney said, it is reported, that he answered an advertisement in a newspaper, inserted by Charles A. Duff, Youngstown, Ohio, and was told to report to "Dr." Mazur at Newcastle. His instructions were to sit around while Mazur did the diagnosing and treating. Duff is said to have explained to Delaney that "they" had their own way of treating. Delaney claims that he soon became convinced that medicine was being practiced illegally at the clinic and that he was preparing to leave when the arrests were made. The trouble seems to have started when Mrs. Mikulec, a patient, complained to the district attorney that "Dr. Duff" had attacked her. According to the Newcastle *News*, it appears that Mazur had been posing as Duff.

Philadelphia

Hospital News.—A continuation of the Presbyterian Hospital campaign for $1,500,000 for the construction of additions to the hospital has been announced. The figures issued showed that $641,236 had been subscribed.——Eastern Delaware County, May 10, opened a drive for $400,000 to erect a hospital. It was announced that $100,000 had already been received. A vote of thanks was given to Thomas Conway, a Delaware County man, who started the hospital movement by donating a $75,000 tract of land on Lansdowne Avenue as a site.——Howard Hospital will erect a new building, costing $350,000, on a site between the present building and Christian Street. Work will start in the near future.

Meeting of Health Council.—At the annual meeting of the Philadelphia Health Council and Tuberculosis Committee, April 17, Dr. Charles J. Hatfield was elected president. The heliotherapy demonstration to be conducted for three years by the council will be in charge of Dr. Richard T. Ellison, under the supervision of Dr. William J. Enders, medical director, Chestnut Hill Home. The council decided to establish a heart disease prevention service, cooperating with the Philadelphia Heart Association. It will consist of educational activities concerning heart disease and the establishment of an employment bureau for persons handicapped by heart disease. The council agreed to participate again in the maintenance of Camp Happy, the summer nutrition camp of the department of public welfare, which will be enlarged to accommodate about 3,000 children.

TENNESSEE

Conference of Laboratory Directors.—The fifth annual conference of the Southern Public Health Laboratory Directors was held in Memphis, recently, and a resolution was adopted to the effect that all laboratories making diagnostic reports on reportable diseases should have a license from the state laboratory. This plan has been successful in New York. Preliminary standards were adopted at this conference for malaria, diphtheria and the Wassermann test.

WASHINGTON

Society News.—The board of trustees of King County Medical Society, Seattle, has contributed $500 toward furnishing the new auditorium of the Medical-Dental Building, which is about equal to a year's rent in the old quarters.

Tuberculosis Foundation to Be Established.—Provision has been made in the will of Mrs. Josephine McDermott, Seattle, for the establishment at the University of Washington of a foundation for investigation and research in tuberculosis. A fund has thus been provided amounting to the income of $100,000.

PHILIPPINE ISLANDS

Health Officers Honored.—A banquet in honor of Dr. Vincente de Jesus, former director of health, and Dr. Jacobo Fajardo, the present director of health, was given by the Philippine Health Service and the Colegio Medico-Farmaceutico, Manila, Dec. 7, 1924. Dr. Gervasio Ocampo was toastmaster, and about 150 physicians and pharmacists were present. Another banquet was given in honor of the retiring and present directors of health, Dec. 23, 1924, by the assistant sanitary inspectors of the Philippine Health Service of the city of Manila.

CANADA

Proposed Legislation on Treatment of Addicts.—Changes in legislation have been proposed in Manitoba which will enable specified officers of the health department to grant hearings to drug addicts and to advise treatment. The object is to avoid hearings before criminal courts.

Annual Meeting at Regina.—The Canadian Medical Association will hold its annual meeting at Regina, June 22-26, and at the same time and place also the Canadian Radiological Association, the Western Branch of the British Medical Association and the Saskatchewan Medical Association. Among those who will speak are Dr. Fraser, Edinburgh; Dr. Herbert W. Carson, London, president of the Hunterian Society, and Dr. Pritchard, Battle Creek, Mich. The parliament buildings and grounds have been placed at the disposal of the association, all city clubs will be open to the visitors, and the Royal Canadian Mounted Police promise a gymkhana. Inquiries should be addressed to Dr. Malcolm R. Bow, General Hospital, Regina, Sask.

GENERAL

Weekly Health Index.—The Department of Commerce is publishing the census mortality reports from large cities, including for each city the number of deaths reported, the rate, the number under 1 year of age, and corresponding information for the previous year. A bulletin with this information is released each week.

Dr. Arnold President of National Board.—At the annual meeting of the National Board of Medical Examiners, Washington, D. C., May 4, Dr. Horace D. Arnold, Boston, was elected president to succeed Surg. Gen. Merritte W. Ireland, who retired from this office after three years of service. Dr. Arnold is the first president of the board from civilian life. He was one of the original members of the board when it was organized in 1915.

Society News.—Dr. Clarence Floyd Haviland, Albany, N. Y., was elected president at the eighty-first meeting of the American Psychiatric Association, Richmond, Va., recently; Dr. George M. Kline, Boston, vice president, and Dr. Earl D. Bond, 4401 Market Street, Philadelphia, secretary-treasurer. The next meeting will be in New York. ——The American Home Economics Association will conduct two round table discussions in connection with the meeting of the National Education Association in Indianapolis, June 28-July 4, on "What Does Home Economics Contribute to the Purposes of Junior and Senior High School Education" and "Progress in Home Economics Education."——At the fifty-first meeting of the American Neurological Association, Washington, D. C., recently, Dr. Frederick Tilney, New York, was elected president; Drs. John J. Thomas, Boston, and Peter Bassoe, Chicago, vice presidents; Dr. Henry A. Riley, New York, secretary, and Dr. Clarence A. Patten, Philadelphia, assistant secretary.——At the twenty-fourth meeting of the National Association for the Study of Epilepsy, Richmond, Va., May 11-12, Dr. George Kirby Collier, Rochester, N. Y., was reelected president; Drs. George G. Kineon, Gallipolis, Ohio, and Daniel S. Renner, Skillman, N. J., vice presidents, and Dr. Arthur L. Shaw, Utica, N. Y., secretary-treasurer (reelected). Dr. Douglas A. Thom, Boston, is chairman of the executive committee. It was suggested by Dr. George M. Kline, Boston, that the American Psychiatric Association, the National Association for the Study of Epilepsy and the American Association for the Study of the Feebleminded merge, yet retain sectional meetings and control. A committee was appointed to consider the matter and report at the next annual meeting.

Committee to Report on Ethyl Gasoline.—The conference held at Washington, May 20, to consider whether or not public health is threatened through the use of ethyl gasoline as motor fuel concluded its session by unanimously passing a resolution asking the Surgeon General of the U. S. Public Health Service to appoint a committee of "seven recognized authorities in clinical medicine, physiology and industrial hygiene to present to him by Jan. 1, 1926, a statement as to the health hazard involved in the retail distribution and general use of tetra-ethyl lead gasoline motor fluid." The resolution further endorsed the "wise decision of the ethyl corporation to discontinue temporarily the sale of ethyl gasoline," while the question of its effect on public health is unsettled. The adoption of the resolution followed an all-day discussion, during which one group insisted that no dangerous health hazard has resulted from the use of ethyl or leaded gasoline; while another group insisted that evidence is at hand showing that the use of the product would involve the health of workers in garages and of the public in communities where heavy traffic exists. The discussion brought out the fact that tetra-ethyl gasoline is one part lead compound and 1,300 parts gasoline. Representatives of the ethyl gasoline corporation said that 300,000,000 gallons of ethyl gasoline had been sold throughout the United States, and that wide inquiry failed to reveal a single person who suffered from lead poisoning as a result of handling the product. Representatives of the industry stated that while eleven persons had died and 149 suffered illness in the manufacture of tetra-ethyl lead, the processes were now so well advanced that the hazard in its manufacture was reduced to the minimum. Reports of investigations at Columbia University, University of Cincinnati and the Bureau of Mines showed that animals were poisoned by the substance in varying degrees. But these reports were not conclusive. Dr. David Edsall, dean of the School of Public Health, Harvard University, stated that, in his opinion, a hazard does exist and that the only way to ascertain the extent of such hazard would be after careful, prolonged and devoted study. Dr. Robert A. Kehoe, University of Cincinnati College of Medicine, stated that the men engaged in the manufacture of tetra-ethyl gasoline were exposed to several possible hazards, but that the elimination of these hazards was made possible by the installation of suitable automatic machinery so that the actual exposure was reduced to a minimum and also the number of employees was reduced. Dr. Royd R. Sayers of the Bureau of Mines told the conference that, after allowing treated gasoline to evaporate in a ventilated chamber, lead constituted about 10 per cent. of the dust found on its floors. Dr. Haven Emerson, professor of public health, Columbia University, New York, stated that a "district industrial hazard did exist, but that it is one not at all beyond the scope of industrial ingenuity and technical skill to control." At the conclusion of the conference, the Surgeon General stated that on account of the importance of the questions involved he would not attempt to pick the membership of the committee but would give the subject careful consideration and consult with the American Medical Association and other professional organizations before choosing the nominees authorized by the resolution.

FOREIGN

Child Marriage in India.—The recent government census in India shows, according to the *China Medical Journal*, that there are 15,000 widows in India under 5 years of age, 100,000 between 5 and 10 years of age, 279,000 between 10 and 15, and more than a half million between 15 and 20. The number for the first age period represents a decrease from that of the preceding census of almost 3,000.

Ratio of Physicians to Population.—The *Schweizerische medizinische Wochenschrift* states that there is one physician to 1,359 inhabitants in Japan; in Sweden, one to 3,500; in Germany, one to 1,500, and in Switzerland, one to 1,290. In 1910, Switzerland had one physician to 1,502. In the United States, we have one physician to 726 inhabitants. The ratio in 1860 was one to 576.

Bequests of Sir Clifford Allbutt.—The estate of the late Sir Thomas Clifford Allbutt, regius professor of physics, University of Cambridge, was valued at £56,963. Among the bequests in his will was that the residue of his property, subject to private bequests, was to go to Gonville and Caius College, Cambridge, to establish Sir Clifford Allbutt Fellowships for medical research or otherwise for the benefit of the college, provided no part be used for building; and that £50 each go to the Medical Charitable Fund for the West Riding of Yorkshire and the British Medical Benevolent Fund. His portrait by Sir William Orpen was given to the Fitzwilliam Museum, Cambridge, as were, on the death of his wife, drawings and paintings by noted artists and a quantity of antique furniture.

CORRECTION

Dr. Rockwell Is Not Dead.—The notice of the death of Dr. Alphonso David Rockwell, Flushing, N. Y. (THE JOURNAL, May 16, p. 1513) was an error. It was Dr. Rockwell's wife who died.

Government Services

Veterans' Bureau Medical Supervisors on "Field Service"

In accordance with the endorsement of the medical council of the Veterans' Bureau and in order to carry out regional and hospital standardization of clinical and administrative service, the directors of the Veterans' Bureau have assigned four medical supervisors on duty in the central office to a tour of so-called "field duty," with stations at New York, New Orleans, Chicago and San Francisco. Dr. Winthrop Adams will take station in New York; his territory will cover thirteen states and the District of Columbia. Dr. Edward P. Odend'hal goes to New Orleans; his territory covers eleven of the Southern states. Dr. Ord Everman is assigned to Chicago to serve thirteen Middle Western states, and Dr. George C. Skinner to San Francisco to serve eleven Western states. It is the plan now to alternate "field" and central office service for staff physicians in order that they may become familiar with all phases of medical administration and that the medical service may become standardized throughout.

Reserve Officers on Active Duty

The following members of the Medical Officers' Reserve Corps have, with their own consent, been ordered to active duty at Carlisle Barracks, Pa., for training from June 16 to June 30: Col. Henry S. Bartholemew, Napanoch, N. Y.; Col. Henry M. Moses, Brooklyn; Col. Maurice L. Townsend, Charlotte, N. C.; Lieut. Col. Henry W. Cattell, Philadelphia; Lieut. Col. Richard S. Davis, Germantown, Philadelphia; Lieut. Col. Erin E. Epting, Anderson, S. C.; Lieut. Col. James Hamilton, Jr., Providence, R. I.; Lieut. Col. Marion H. Wyman, Columbia, S. C.; Major Edward L. Ayme, New York; Major George A. Grieumard, Fitchburg, Mass.; Major Albert Smith, Washington, D. C., and Capt. Richard Kimpton, Columbus, Ohio.

U. S. Public Health Service

Surg. Joseph Goldberger was directed, May 5, to proceed from Washington, D. C., to Chicago, Peekskill and Tuckahoe, N. Y., and Milledgeville, Ga., in connection with pellagra studies. A. A. Surg. Charles P. Coogle was directed to proceed from Greenwood, Miss., to Tutwiler and Greenville to investigate an outbreak of typhoid fever in that vicinity. Surgs. Paul Preble, Louis L. Williams, Jr., P. A. Surg. Claude W. Mitchell and Asst. Surg. Hugh J. McLaughlin were directed, May 2, to proceed from their respective stations to Washington, D. C., for temporary duty in connection with the prevention of smallpox.

Respiratory Disease in the Army

In a review of the health of the army for the first seventeeen weeks of 1925, the Surgeon General's Office notes that the admission rate for all causes for troops in the United States was higher than in 1924, the principal reason being the prevalence of respiratory diseases, for which the rate was 253.2, as compared with 200.2 in 1924. The admission rate for influenza for 1925 (60.17) was also higher than 1924 (18.28). Notwithstanding this increase, there was an actual and a relative decrease in the number of cases of primary pneumonia, the admission rate being 4.0, as compared with 4.6 in 1924. There was, however, an increase in the relative and absolute number of secondary pneumonias, the rate being 0.97 as compared with 0.53. There were during this period in 1925, twenty-three deaths from primary pneumonias and five from secondary pneumonias. The admission rate for the common respiratory diseases was higher in the seventh corps area than in any other and lowest in the fourth corps area, which had the highest influenza rate; the ninth corps area had the lowest influenza rate. The outbreaks of influenza at Fort Riley comprised 206 cases, and at Camp Benning, 435 cases. There were smaller epidemics of influenza at Fort Washington (thirty-six cases), Fort Benjamin Harrison (ninety cases), at Fort Sam Houston (172 cases) and at other stations.

Foreign Letters

LONDON

(From Our Regular Correspondent)

May 16, 1925.

Clash of Expert Evidence in a Murder Trial

In the trial of a man named Thorne for the murder of his sweetheart, whose dismembered body was found buried in his chicken farm, the evidence of the two leading medicolegal pathologists of the day was so conflicting as to cause some uneasiness among the public as to the conviction, for which otherwise the evidence was overwhelming. It was proved that the girl visited Thorne, December 5. Her body was found, January 15. Sir Bernard Spilsbury, the pathologist who is employed by the government as an expert in all important cases, gave evidence that he found bruises on the face, head and elsewhere which might have been caused by violence. The defense put forward by Thorne was that the girl visited him on the night in question, that he went out to meet another girl, and on his return found the deceased hanging from a beam, dead. Being afraid, he cut the cord, burned her clothes, sawed off her legs and head, and buried the remains. Sir Bernard said that he could find no marks on the neck indicating hanging and expressed the opinion that death was due to shock from the violence that caused the bruises. For the defense, a lecturer on mental disease stated that, from the evidence, he considered the deceased highly neurotic and potentially suicidal. Another physician who assisted at a second necropsy, made at the request of the defense, said that a bruise on the head might have been caused by a fall and that he would have expected a bruise on the right cheek, if caused by the severe violence suggested by the prosecution, to have caused damage to the bone, of which there was no sign. He also described two grooves on the neck three-eighths inch apart, but later a note was made, "Equally creases." He also produced microscopic slides which he said indicated extravasation of blood in the neck. Death might have been due to hanging. Asked as to Sir Bernard Spilsbury's position as a pathologist, he admitted that he was an extremely high authority but "a trifle dogmatic."

The most extraordinary feature of the case, however, was the evidence of Dr. Bronte, a medical legal pathologist second in eminence only to Sir Bernard Spilsbury and also a government expert. He did not think it possible after the body had lain in a clay soil for six weeks to distinguish, as Sir Bernard Spilsbury had attempted, between the bruises as to the order in which they occurred. Sir Bernard said that the bruises might have been caused by blows from a firm object, such as an Indian club, which was found on the farm. But in this case the skull was very thin and Dr. Bronte thought it would have smashed like an eggshell. But there was no fracture, and his view was supported by the fact that there was also no laceration of the skin. Microscopic examination of the skin of the neck showed bruises, which were consistent with the pressure of a rope. A rope round the neck lying between the two grooves might have produced them in the process of hanging. In his opinion the cause of death was shock following an unsuccessful or interrupted effort at self-strangulation. It was possible that any or all of the bruises might have been caused between the moment of cutting down from the point of suspension and placing the body on the bed. In cross-examination it was suggested that an expert could tell the difference between a bruise caused fifteen moments before death and one caused immediately before. He disagreed. He considered that Sir

Bernard Spilsbury made one mistake in not examining the marks on the neck microscopically. Asked whether the two creases on the neck were not present in most women, he said that in young persons one mark was very common, but he had not seen two so frequently. Dr. D. N. Nabarro, director of the pathologic department of Great Ormond Street Hospital, said that he had examined the slides and discovered in those from the neck definite extravasation of blood, indicating injury by pressure. He thought that pulping of the tissues was due to putrefaction and not to a blow, as Sir Bernard Spilsbury had suggested. Dr. H. M. Galt, professor of legal medicine, Glasgow University, said the condition of the neck as revealed by the slides was consistent with partial and temporary suspension of the body.

Sir Bernard Spilsbury was recalled. He said that if a string of the sort described by the prisoner had been used with a slipknot round the girl's neck, when unconsciousness supervened he would expect, with the weight of the body on it, that it would make a deep groove completely encircling the neck, not the two grooves described. With regard to the microscopic slides, his opinion was that what the other experts saw was the degenerated remains of sebaceous glands and they showed no evidence of injury. As to the injury to the cheek, the tissues were clearly pulped, and this could not be explained by a fall.

Dr. Galt was recalled. He had seen many cases of hanging and never found that the knot had completely slipped. This was opposed to the law of physics. There was never tightening at the back of the neck.

The judge, in his summing up, said that it did not follow that because the slides showed extravasation of blood, it was caused by a rope. Was the prisoner's conduct on the night of the death consistent with the theory of suicide? The prisoner was found guilty.

The case then came before the court of criminal appeal, where the unusual application was made to appoint an assessor with expert knowledge to report on the medical issues of the case. In refusing this, the lord chief justice said that the jury had overwhelming evidence on which to act. There was no ground for the suggestion that it failed to appreciate, or would not be likely to have the capacity to discriminate between, the conflicting views put before it on the medical and surgical aspects of the case.

However, the general uneasiness caused by the contradictions of the medical evidence is shown by a question to the home secretary in parliament as to the disadvantage that might attach to a person accused of murder or manslaughter in the conduct of his defense arising from the practice of appointing one physician only to conduct a postmortem examination; and whether he would take steps to insure that, when a person died in circumstances that may lead to a criminal charge and a postmortem examination is held, a physician shall be appointed to watch the examination in the interests of any persons to be charged. In reply, the home secretary did not see his way to propose legislation for this purpose. He considered a postmortem examination not a matter of advocacy, but of scientific investigation. The director of public prosecutions was, however, considering whether it may not be possible to arrange that the defense shall have the opportunity of appointing a physician to be present on behalf of the defendant when the postmortem examination is performed.

Pure Milk

At a recent meeting of the combined sections of epidemiology, comparative medicine and diseases of children of the Royal Society of Medicine, an important discussion took place on the control of tuberculosis and the milk supply. Dr. John Robertson, health officer of Birmingham, said that during the last eighteen years the percentage of cans of milk sent into Birmingham containing living tubercle bacilli averaged 8.7 but the figure was decreasing. Of the 7,500,000 head of stock in Great Britain, some 3,000,000 were in milk, and of these at least 1,000,000 were infected with tuberculosis, though in many cases so slightly that it did not affect their well being. In Manchester, 10 per cent. of the milk samples taken showed living tubercle bacilli, and, unlike Birmingham, the proportion had increased since 1901. Nevertheless, farm inspection had revealed tuberculosis of the udder in 597 cows during that period, and these were mostly animals producing plenty of milk, and in the middle of their active period, so that some good must have been done by the elimination of that amount of infection. The piecemeal measures so far adopted had done nothing to reduce the incidence of bovine tuberculosis. Dairy farmers as a class were unable to appreciate the value of preventive medicine, and were liable to regard any progressive measure with suspicion. Dr. Robertson was in favor of the freeing of dairy herds from tuberculosis, but, in view of the slowness and difficulties of this method and the need of many more veterinary officers, of much greater expenditure on cowsheds, and of prolonged education of agriculturists, he recommended other and additional means of safeguarding public health which would be practicable to apply throughout the country.

Dogs' Protection Bill

In the House of Lords, Lord Banbury has again brought in a bill to protect dogs against vivisection. In moving the second reading of the dogs' protection bill, he said that a similar measure had three times passed the second reading in the other house, and on one occasion was reported to the house from a standing committee without amendment. The passing of the bill would in no way prevent experiments from being made on other animals; all it would do was to prevent them from being made on dogs. The use of dogs in vivisection was unnecessary, as the knowledge that had been or could be obtained from that source could be secured in some other way.

Viscount Knutsford, in moving the rejection of the bill, pointed out that if the bill passed, no dog could ever be used for any experiment, even an experiment without pain, a feeding experiment, or an experiment with a view to getting rid of distemper. He did not suppose that the whole medical and surgical world had ever been so unanimous on any subject as it was on that question. They were all reluctant to use dogs for experiments, but they were compelled to do it because it was necessary for the advance of knowledge. It was almost unthinkable that that house should venture to set its opinion against that of the whole medical and surgical world. Diabetes was no longer a sentence of death on young boys and girls and was no longer an intolerable burden on adults, thanks wholly and solely to experiments on dogs. If they had a chance of lessening suffering, of benefiting mankind, it would be gross cruelty to refrain from gaining that knowledge. The bill was rejected by seventy-seven votes to eight.

The British Spa Federation

At the annual meeting of the British Spa Federation, representing the principal spas in Great Britain and the New Zealand government spas, the following conditions of membership were adopted: (1) natural mineral waters of proved therapeutic value; (2) a bathing or pump room establishment approved by the federation; (3) an available suitable local medical authority devoted to spa practice; (4) proper hotel accommodation in the immediate vicinity; (5) treatments to be given only under medical prescription, not more than twelve months old, except in the case of certain minor treatments definitely specified by the local controlling

authority; (6) the amenities, and sanitary and other conditions of the spa to be approved by the federation; (7) the control of the spa to be in the hands of a public body, or an approved private body. It was further resolved that before the admission of any spa, the federation shall depute three representatives, one of whom shall be a spa physician appointed by the federation, to visit the spa and report fully thereon to the federation. The federation emphasizes the necessity of a high standard of practice at the British spas, and insists on its members working in conjunction with the medical profession. It is the aim of the federated British spas by these and other means, combined with the research work now going on at several spas, to provide physicians with hydrologic centers in this country at which they may be sure of their patients receiving efficiently administered treatment. The federation also decided to cooperate with the International Society of Medical Hydrology in its scheme for lectures on medical hydrology at the university and hospital medical schools.

PARIS

(From Our Regular Correspondent)

May 14, 1925.

The Estimation of the Degree of Disability of Tuberculous Persons

The presidential decree of Aug. 8, 1924, supplemented by the ministerial instructions of Aug. 14, 1924, modified the decree of Oct. 17, 1919, which was then in force. The decree of Oct. 17, 1919, accorded full disability with a 100 per cent. pension only to tuberculous subjects in whom evolutive pulmonary tuberculosis, associated with the finding of tubercle bacilli in the sputum, was diagnosed. The new decree of Aug. 8, 1924, stipulated that the estimation of the degree of disability claimable by such subjects, irrespective of the momentary gravity of the disease, should be fixed at 100 per cent., and that a corresponding temporary or permanent pension should be granted in each case. It specified explicitly that the allowance of 100 per cent. disability did not require that the lesions should be of an evolutive nature nor that there should be an agreement between the clinical symptoms and the bacteriologic evidence. Competent phthisiologists agree that the decree of Aug. 8, 1924, presents certain difficulties.

The whole problem has been discussed by the Société des médecins de sanatoriums et de dispensaires l'hygiène sociale. This organization holds that: 1. The period of two months' observation, together with the latitude given to experts, should be sufficient to enable them not merely to "assume" a diagnosis of pulmonary tuberculosis but actually to reach such a diagnosis on the basis of precise findings. 2. When unsupported by positive tests for tubercle bacilli, the lung signs by no means justify granting a disability of 100 per cent. 3. The establishment of a disability of 100 per cent. is justified only in cases in which tuberculosis is found to be active or susceptible of activity owing to the presence of tubercle bacilli as established during the two months accorded for the expert examination or within twelve months just preceding the examination.

In view of the foregoing facts, the Société established the four following groups of cases: Group 1: If an applicant for a pension has never had tubercle bacilli in the sputum, and does not present such bacilli after repeated examination, it is impossible to grant a pension of 100 per cent. However, a reduced pension may be granted if there are definite roentgenologic and clinical signs, associated with functional disorders, that bring about an actual diminution of the working capacity. Group 2: If an applicant presented tubercle bacilli in the sputum more than one year previous to the expert examination but does not present such bacilli after repeated researches during the two months accorded for the expert examination, it is impossible to reach a diagnosis of existing tuberculosis, and the pension allowed will be under 100 per cent. Group 3: If an applicant for pension presented tubercle bacilli in the sputum during the twelve months just preceding the expert examination and does not present such bacilli after repeated researches during the two months accorded for the expert examination, the diagnosis of pulmonary tuberculosis must be maintained and a full pension on a 100 per cent. basis be granted, provided there are frank roentgenologic and clinical signs in agreement with the previous finding of tubercle bacilli. In the complete absence of these signs, the pension must be under 100 per cent. Group 4: If an applicant for pension presented tubercle bacilli in the sputum during the two months accorded for the expert examination, a positive diagnosis will be reached and a pension of 100 per cent. will be granted. However, in the complete and continued absence of all roentgenologic and clinical signs, an investigation should be instituted to make sure that an error was not committed in the laboratory, which is always possible.

The society recommended also that after the lapse of a year, applicants to whom a 100 per cent. pension had been granted should be reexamined, preferably by the same expert as before, with a view to reviewing and decreasing, if there is reason for such action, the percentage originally granted.

In the interval, and in view of a possible revision, the establishment of regular and compulsory supervision of pensioners by the dispensary would be a practical and easy means of control.

Social Service in the Hospitals

The Service social à l'hôpital has published the transactions of its third general assembly, which was held, Feb. 9, 1925, under the chairmanship of M. Mourier, director of the general administration of the Assistance publique in Paris. Social service work in hospitals is new in France, but it has already proved its value in other countries. Its public usefulness was first recognized here in 1922. It has been given financial support by the municipal council, the general council of the Seine and the minister of public health, and also receives gifts from a number of other public and private sources.

Thirty-three hospital services in Paris are provided with social service. These services are divided into five classes: the children's section, the section for tuberculous subjects, the section for mothers (including prospective mothers), the medical section and the surgical section.

At the general assembly, several papers were presented; among others, that of Dr. Rist, physician to the Laënnec Hospital and one of the vice presidents, which gave a good idea of the importance of the undertaking and of the nature of the results already secured. The figures given in his paper show that the social service work is developing. In 1923 the number of patients taken charge of was 11,060, and in 1924 the number rose to 14,050. In 1923 the number of visits (including special services) amounted to 13,633, while in 1924 the number increased to 16,061.

The problems of the Assistance sociale vary markedly with the section in which the workers are employed. In the maternity sections, its rôle is of paramount importance. It points out to prospective mothers the numerous societies, public and private, that are ready to assist her (house of refuge, maternity center, maternity homes, consultation centers for prospective mothers and young mothers, rewards for breast feeding, monetary assistance during pregnancy, assistance to prevent desertion). The social workers have here two chief ideas in view: to prevent mothers from desert-

ing their new-born children, and the promotion of breast feeding.

In the section for tuberculous subjects, the Assistance sociale serves as a connecting link between the hospitalized patients and their families. They give advice to families; see to it that the necessary prophylactic visits to the dispensary are made, and look after the placing of children not yet infected or already contaminated. They supervise patients who are receiving pneumothorax treatment and require external consultations. They endeavor to secure for cured patients employment compatible with the maintenance of their health.

In the children's section, the Assistance sociale supervises extramural consultations. They see to it that medical prescriptions are rigorously followed, and thus obviate the necessity of hospitalization when it may not be feasible. Through the mediation of the social workers, children who should be taken out of the environment of their own families may profit by the numerous public and private societies.

In the antivenereal services, and likewise in the medical and surgical services, the Assistance sociale renders valuable service; but in the medical and the surgical sections its work would be greatly facilitated if there were more opportunities of placing chronic patients; especially, aged patients who encumber the services to such an extent that there is not sufficient room to handle the acute cases.

M. Rist gave also the figures that showed what work had been done by the society in 1924. These activities concern the placing of 1,095 adults and 1,859 children.

The Appointment of Two New Professors on the Paris Medical Faculty

Two new professors on the Faculté de médecine of Paris recently delivered their inaugural addresses: M. G. Roussy, professor of pathologic anatomy, who succeeded M. Letulle, and M. Ombredanne, professor of orthopedic surgery, who succeeded M. August Broca, recently deceased.

M. Roussy had been for a number of years the director of work in pathologic anatomy. It was with his collaboration that Prof. Pierre Marie introduced many needed reforms in instruction in pathologic anatomy, allowing his students thus to benefit from more modern methods of demonstration. Roussy is the author of many excellent works, which have made him well and favorably known to many of his colleagues. For many years he has been the director of a large cancer service in the Villejuif Hospice, and has devoted a large part of his energies to the study of experimental cancer and of radiotherapy. No one knows better than he what a great service experimental medicine is able to render to pathologic anatomy. There is no doubt that a brilliant career lies before him.

M. Ombredanne is the inventor of a well known apparatus for the administration of ether, and has acquired fame in the field of plastic surgery. He is an excellent surgeon and a remarkable instructor. He well deserves the post that has been entrusted to him.

The Franco-Polish Medical Congress

During the last Franco-Polish Medical Congress two of the most eminent members of the assemblage—both of Polish origin—Madame Curie and M. J. Babinski, delivered addresses at the same meeting. Madame Curie discussed radioactive bodies utilizable in medicine, and recalled that among these only two, radium and mesothorium, are employed as therapeutic agents, although many others, whose properties she mentioned, were deserving of experimentation. Dr. Babinski explained his observations on the patient who aided him, twenty-five years ago, in establishing the elements of his cerebellar syndrome. He presented the film that was taken at the time, which has great documentary and historic value. He projected on the screen also the anatomicopathologic preparations showing the nerve lesions that his patient, who died from cancer of the stomach, presented.

BERLIN

(From Our Regular Correspondent)

April 25, 1925.

The Regulation of Medical Specialties

The standards adopted at the Bremen medical convention with respect to medical specialties, as previously reported (THE JOURNAL, March 7, p. 764), have been tacitly accepted in many parts of the country and are also being applied. In the medical press we have seen references to only two sections that have taken definite action in the matter—namely, Hamburg and Wurttemberg. At the plenary assembly of the Hamburgische Aerztekammer, held Oct. 11, 1924, the following resolution was adopted and incorporated in the code of ethics governing the medical profession:

The assumption of the title "specialist" (*Facharzt*) or the statement that a physician is specializing in any particular branch of medicine is not permissible except on the basis of adequate special training. The specialist must confine his practice absolutely to his chosen field and must not accept cases that do not come within the limits of his specialty. The testing of an applicant's training and his recognition as a specialist shall be in the hands of an examining committee, to be chosen by the Aerztekammer for a period of two years. The committee shall be composed of three general practitioners, three specialists and a member of the Aerztekammer (who is not on the executive committee) to act as chairman. The committee shall be governed in its decisions by the standards set up by the plenary assembly of the Aerztekammer. An applicant shall have the right to appeal from a decision of the examining committee to the executive committee, whose decision shall be final. Any physician who desires to locate in Hamburg as a medical specialist, or wishes to assume such title, must file an application with the examining committee.

The plenary assembly of the Aerztekammer, of Oct. 11, 1924, adopted standards for the guidance of the examining committee, which correspond closely to the criteria proposed by the Bremen convention.

At the meeting of the Aerztlicher Landesausschuss in Wurttemberg, Oct. 25, 1924, the criteria adopted by the Bremen convention were accepted by Wurttemberg. The Landesausschuss has requested the district organizations to endorse its action and to appoint at once the needed examining committees. The Landesausschuss has also established a board of appeal consisting of the representative of the medical faculty in the Landesausschuss to act as chairman; two general practitioners, and two specialists, who may, but need not, be members of the Landesausschuss. In addition, in the contract between the panel physicians and the health insurance societies a provision has been incorporated which compels the *Kassen* to recognize the authority of both the local examining committee and the board of appeal set up by the Landesausschuss.

Specific and Nonspecific Tabes Therapy

Before the Frankfort Medical Society, G. L. Dreyfus, the neurologist, recently gave an instructive address on the treatment of tabes. Many neurologists are disinclined to give any form of treatment in tabes, since a rational treatment is one of the most difficult and complicated tasks confronting the neurologist. If treatment is given, along with the improvement of certain tabetic symptoms there may be an exacerbation of other symptoms; for example, optic atrophy. A recrudescence or the persistence of especially painful symp-

toms may prevent the patient from continuing treatment. The technical question (intravenous injection) may cause difficulties. The anatomic changes in the central nervous system (the simultaneous occurrence of inflammatory and degenerative processes) often limit the possibilities of treatment. Then, too, tabetic patients are unusually sensitive to rigid treatment and also to many medicaments; for example, mercury.

The fundamental rule in tabes therapy is to proceed cautiously. Of the specific remedies to be considered, may be mentioned: (1) arsphenamin preparations; (2) mercury; (3) iodin (often given intravenously by Dreyfus with good effect, especially in ataxia), and (4) bismuth preparations. Of the nonspecific methods of treatment, Dreyfus recommends, from his own experience: (1) strengthening of the whole constitution; (2) proteotherapy; (3) injection of killed bacteria; (4) induction of fever by tuberculin, intravenous injection of killed typhoid bacilli, or inoculation with recurrent fever or malaria. According to Dreyfus, induction of fever has good therapeutic possibilities in tabes as well as in general paralysis. Often a marked therapeutic effect may be secured by the combination of specific and nonspecific preparations or methods.

Dreyfus reported the nature of the improvement that he had effected in more than 500 tabetic patients, some of the cases dating back twelve years or more. He records 25 per cent. of failures and 75 per cent. of cases in which the condition of the patients was improved, half of these showing marked improvement.

State Aid for Needy and Expectant Mothers and Lying-In Patients

On the basis of the act of Feb. 13, 1924, regulating the duties of the state with respect to the dispensing of public charity, the principles of federal law, issued, Dec. 4, 1924, establish the nature of the aid that the state must furnish needy expectant German mothers and lying-in patients. Depending on the nature and degree of need, medical assistance, part of the cost of confinement, a weekly cash benefit, and in the case of breast feeding a special stipend, will be granted. Expectant mothers and lying-in patients who are in need must be assured such aid as the federal insurance act affords all members of a family whose head is insured in a health insurance society (weekly family allowance). For cash benefits, performances or contributions in kind may be substituted. A person is needy if he is unable, through reliance on his own strength and resources, to procure for himself and dependents the ordinary necessaries of life, and is not in a position to secure them from friends and relatives. Every needy person, even though he may not possess full earning capacity, must make full use of his time and strength to procure for himself and dependents the necessaries of life. . . . Whether a needy person can be reasonably expected to do certain work will depend on his or her age, condition of health, and domestic relations. . . . Women shall not be expected to become wage earners if, thereby, the proper rearing of their children is endangered; and, in other respects as well, the special duties that devolve on women, in connection with housekeeping and the care of the family, must be considered. As a rule, persons temporarily in need will be expected to refund to the authorities such sums as are expended in their behalf, but no demands for repayment shall be made unless it is apparent that such action will work no hardship. The several states or provinces may pass further legislation in regulation of the granting of public charity. Detailed information concerning aid for expectant mothers and lying-in women may be secured from the *Bezirksfürsorgeverband* (welfare league) or at other welfare and public health centers.

RIO DE JANEIRO

(From Our Regular Correspondent)

April 15, 1925.

Surgical Treatment of Ozena

Dr. Heitor Fróes, assistant professor of the Bahia Medical School, has introduced a modification of Lautenschläger's method for the treatment of ozena. In treating the disease, the aim is usually to narrow or reduce the fossae, drawing the nasosinusal walls nearer the septum, so that they cannot return to their original location. For this purpose, Lautenschläger mobilizes the walls. Approach is through the antrum. To hold them in position, the antrum is packed for from two to four months. As this method sometimes fails, Seiffert anchors the walls to the septum with a thick silk thread. Even this may prove unsuccessful, as the thread may yield or tear the lateral walls. Several authors have also tried threads and plates of metals.

Dr. Fróes uses silver threads and plates. These are left in position indefinitely, this foreign body being perfectly tolerated. His technic is as follows: Under anesthesia, both maxillary sinuses are opened extensively from the canine fossa in order to have free access, but without sacrificing the cosmetic appearance. The condition of the sinusal mucous membrane is determined. If changes are found, removal is necessary. The silver thread is passed through the lateral walls and the septum, and is held by two 15 by 8 mm. plates, also of silver, in the antrum. Care is taken to mobilize the posterior part, in order that the nasal fossa shall be narrower anteriorly than posteriorly. Fróes stresses the importance of this point. Mobilization of the side wall must be very careful. This maneuver is facilitated by freeing the mucous membrane from the antrum. As soon as the walls are sufficiently mobilized, they are anchored to the septum. This requires much care and patience. The thread is twisted with forceps. The operation is completed by packing the maxillary sinuses with gauze for from two to five days. Such technic has given very satisfactory results to its advocate.

Intra-Ocular Cysticercus

Drs. Penido Burnier and Belfort Mattos of the Campinas Ophthalmologic Institute found seventeen cases of ocular cysticercosis among 24,000 patients examined during a period of ten years. This compels us to consider the possibility of a subretinal cysticercus, in the cases of detachment of an obscure causation. On the other hand, many Brazilian ophthalmologists consider such cases to be extremely rare. In one of the last sessions held by the São Paulo Medical and Surgical Society, Burnier and Mattos described the last three cases of eye cysticercus examined by them. One of them was in a woman, aged 30, who two months before began noticing blurred vision in the right eye. There were three well outlined subretinal sacs made by the cysticercus and given up successively until lodging far down in its fourth nest. The macular zone was free, but without any vision, because of the neighboring sac. There were several white dots in the retina, rare floating masses in the vitreous, and infiltration of the disk, but without hemorrhage. The cysticercus was quite deep in the macular region in the posterior pole. Its characteristic voluntary movements were very marked. The scolex was dissociating itself in the interior of the vesicle, in the central macula lutea. The parasite was located very accurately by Dupuy-Dutemps technic, with the help of the perimeter. The operation was a complete success.

Treatment of Intestinal Schistosomiasis

Dr. Heraldo Maciel, a physician in the Brazilian navy, has published his impressions on the rôle of antimony and potassium tartrate in the treatment of intestinal schistosomiasis. His cases amounted to 450. After trying successively

antimony and potassium tartrate, emetin hydrochlorid, neoarsphenamin and methylene blue, Dr. Maciel gives the preference to antimony and potassium tartrate, since its effects are more reliable, and it lacks certain disadvantages. In accordance with the recommendations of the Brazilian scientist Dr. Gasper Vianna, Dr. Maciel begins injecting 5 c.c. of 1 per cent. solution the first day, and from then on 10 c.c. a day, until completing ten injections amounting to 0.95 gm. The injections are usually well borne. However, some patients may show intolerance phenomena, such as cough attacks, salivation, nausea and vomiting. Such symptoms subside completely on administration of from 2 to 6 drops of 1:1,000 epinephrin solution. The only disadvantage of the method is thus obviated.

After a thorough trial of antimony and potassium tartrate in schistosomiasis, and a review of the literature since the publications of McDonagh and Christophersen, Maciel comes to the following conclusions: Neo-arsphenamin and methylene blue are drugs that have no place in any campaign against *Schistosoma mansoni*. Antimony and potassium tartrate and emetin hydrochlorid have real value when applied intravenously. With both antimony and potassium tartrate and emetin, the treatment can be completed in ten days. This is a great advantage, not only for a physician having to treat many patients, but also in a primitive environment, where patients shirk prolonged treatment. The proper doses are: antimony and potassium tartrate, 0.95 gm. in ten injections, 0.05 gm. for the first, and nine of 0.10 gm.; emetin, 0.6 gm. in ten injections: one, 0.04; two, 0.05; three, 0.06, and four, 0.07 gm. On account of its price, reliability and fewer contraindications, antimony and potassium tartrate is the drug of choice. Emetin hydrochlorid should be reserved for patients who cannot take antimony and potassium tartrate. The ingestion of some drops of 1:1,000 epinephrin solution in a little water, just after injection of antimony and potassium tartrate, prevents mishaps due to intolerance, and epinephrin is also the best means to treat such occurrences. Antimony and potassium tartrate and emetin kill the adult schistosomas, but do not influence the eggs. After receiving the proper dose of antimony and potassium tartrate or emetin, the patient does not expel any more eggs of the parasite. Treatment by antimony and potassium tartrate or emetin hydrochlorid offers a reliable means for prophylaxis, as the discharge of eggs ceases, and this source of infection comes to an end.

Moura Brasil Prize

In the first session of the National Academy of Medicine, held, April 5, Dr. Gabriel de Andrade announced the creation of the "Premio Moura Brasil" for the best paper presented each year on ophthalmology. The prize consists of a conto of reis (about $105), and will last through the lifetime of the giver. This is another tribute to the revered master of ophthalmology in Brazil, who has just received so many signs of appreciation on his completing fifty years of practice.

Marriages

THOMAS CRAIG REDFERN, Winston-Salem, N. C., to Miss Dorothy Louise Faucette of Burlington, recently.

THEODORE FRANK FOSTER, Cincinnati, to Miss Anne M. Sattler of Mansfield, February 9.

DAVID JENNINGS ROSE to Miss Janet Conway, both of Goldsboro, N. C., April 11.

NATHAN SAMUEL SCHIFF to Miss Sylvia Minskoff, both of New York, May 26.

WILLIAM T. HYATT to Miss Ruth F. Monroe, both of St. Louis, April 3.

Deaths

Samuel Taylor Darling ✠ Baltimore, was killed in an automobile accident, May 20, near Beirut, Syria. Dr. Darling was born in New Jersey in 1872, and graduated from the College of Physicians and Surgeons, Baltimore, in 1903. He was appointed chief of laboratories of the Isthmian Canal Commission, Panama Canal Zone, in 1906, and in 1913 accompanied General Gorgas on a sanitary mission to the Rand Mines and Rhodesia, South Africa. In 1915 he joined the staff of the International Health Board, and for the next three years was head of a commission that investigated the causes of anemia in Malaya, Java and Fiji. From 1918 to 1920, he was professor and director of laboratories of hygiene in the Medical School of São Paulo, Brazil, and since 1920 director of a laboratory for research in malaria at Leesburg, Ga. Dr. Darling was recently appointed corresponding member of the Malaria Commission of the League of Nations, and while in that service the accident occurred that caused his death. He was president of the American Society of Tropical Medicine, 1924-1925; a member of many scientific societies, and the author of numerous studies on tropical diseases.

Thomas Wright Jackson, Lake City, Fla.; Jefferson Medical College of Philadelphia, 1892; formerly lecturer on tropical diseases at his alma mater; at one time physician to the bureau of health for the Philippine Islands and medical director of Bucks County, Pa.; veteran of the Spanish-American and World wars; on the staff of the U. S. Veterans' Hospital, No. 63; aged 55; died, April 27.

John McWilliams Berry ✠ Albany, N. Y.; Johns Hopkins University Medical Department, Baltimore, 1901; member of the American Roentgen Ray Society; clinical professor of orthopedics and roentgenology at the Albany Medical College; on the staffs of the Child's and Albany hospitals; aged 48; died, May 13, of septicemia.

Henry John Cole Corrigan ✠ Providence, R. I.; Columbia University College of Physicians and Surgeons, New York, 1902; member of the New England Branch of the American Urological Association, Boston; urologist to St. Joseph's Hospital for eighteen years; aged 49; died, May 16.

Albert D. Warner, Burton, Ohio; University of Wooster Medical Department, Cleveland, 1875; member of the Ohio State Medical Association; for ten years member of the school board; formerly mayor of Burton; aged 78; died, April 25, following a long illness.

Carl Cleghorn Warden ✠ Ann Arbor, Mich.; University of Michigan Medical School, Ann Arbor, 1895; member of the Society of American Bacteriologists; on the staff of St. Joseph's Mercy Hospital, where he died, May 1, following a long illness, aged 56.

Edward Bigelow Woods ✠ Pittsburgh; Columbia University College of Physicians and Surgeons, New York, 1907; member of the Central States Pediatric Society; on the staff of St. Margaret's Hospital; aged 45; died, May 1, of carbon monoxid poisoning.

Joseph William Schaeffer, Brooklyn; Long Island College Hospital, Brooklyn, 1897; member of the Medical Society of the State of New York; on the staff of St. Catherine's Hospital, where he died, May 3, of pneumonia, following influenza, aged 49.

John Joseph Derven ✠ Poultney, Vt.; University of Vermont College of Medicine, Burlington, 1906; past president of the Rutland County Medical Society; formerly health officer; aged 43; died, May 1, at St. Joseph's Sanatorium, Asheville, N. C.

James Frank Trucks, Birmingham, Ala.; Medical Department of the Tulane University of Louisiana, New Orleans, 1907; member of the Medical Association of the State of Alabama; aged 42; died, April 20, at a local infirmary, of septicemia.

Roy Wendell Crandell, Warrensville, Pa.; University of Pennsylvania School of Medicine, Philadelphia, 1922; member of the Medical Society of the State of Pennsylvania; aged 28; died, April 28, of injuries received in an automobile accident.

Needham Bryant Broughton, Raleigh, N. C.; University of Pennsylvania School of Medicine, Philadelphia, 1919; member of the Medical Society of the State of North Carolina; aged 34; died, April 21, of acute myocarditis and nephritis.

William Gray Vermilye, Brooklyn; Chicago Medical College, 1884; for several years ship surgeon on the Ward Line; aged 72; died, May 2, at the U. S. Marine Hospital, No. 21, Stapleton, of chronic myocarditis and chronic nephritis.

Ada R. Thomas ✠ Washington, D. C.; Woman's Medical College of Pennsylvania, Philadelphia, 1893; on the staff of the Sibley Memorial Hospital; aged 56; died, May 1, at the Garfield Memorial Hospital, of meningitis.

J. Franklin Welch ✠ Salisbury, Mo.; Missouri Medical College, St. Louis, 1880; past president and for twenty-seven years treasurer of the Missouri State Medical Association; aged 69; died, April 23, of heart disease.

Alanson Cooper Bailey, Randolph, Vt.; Medical Department of the University of the City of New York, 1877; member of the Vermont State Medical Society; aged 74; died, March 5, of injuries received in a fall.

Cornelius Jansen Hasbrouck, Bristol, R. I.; Albany (N. Y.) Medical College, 1873; member of the school board for four years and for two years member of the town council; aged 73; died suddenly, April 26, of heart disease.

Stokly P. Towles, Moberly, Mo.; College of Physicians and Surgeons, Keokuk, Iowa, 1898; member of the Missouri State Medical Association; mayor of Moberly; aged 50; died, April 23, of cerebral hemorrhage.

James Stebbins Carman, Lodi, N. Y.; Howard University School of Medicine, Washington, D. C., 1885; member of the Medical Society of the State of New York; aged 69; died, May 5, while en route to Florida.

Adolph H. Voigt, Oostburg, Wis.; Milwaukee Medical College, 1910; member of the State Medical Society of Wisconsin; member of the board of education for three years; aged 51; died, April 21, of tuberculosis.

Jesse Howes Averill, Campello, Mass.; Medical Department of the University of the City of New York, 1878; member of the Massachusetts Medical Society; aged 71; died, April 24, following a long illness.

Frank Alonzo Foye, Los Angeles; College of Physicians and Surgeons, Los Angeles, 1912; member of the California Medical Society; served during the World War; aged 44; died suddenly, April 28.

William Rufus Kelly, McConnelsville, Ohio; Jefferson Medical College of Philadelphia, 1863; member of the Ohio State Medical Association; Civil War veteran; aged 87; died, April 26, of senility.

Samuel Tanner Patterson, Breda, Iowa; Creighton Medical College, Omaha, 1907; served in the M. C., U. S. Army, during the World War; aged 39; died, May 5, at Des Moines, of influenza.

William A. Minnick, Wichita, Kan.; Kentucky School of Medicine, Louisville, 1881; member of the Kansas Medical Society; aged 70; died, in April, of pneumonia and cerebral hemorrhage.

Frederick Hoyer Millener, Omaha; Jefferson Medical College of Philadelphia, 1894; member of the Nebraska State Medical Association; aged 52; died, April 30, at Alpine, Calif.

Henry J. Stubbs ✠ Wilmington, Del.; Jefferson Medical College of Philadelphia, 1869; aged 76; died, April 30, at the Lankenau Hospital, Philadelphia, following an operation.

Eugene E. Hester, Paxton, Ill.; Eclectic Medical Institute, Cincinnati, 1899; member of the Illinois State Medical Society; aged 53; died, April 28, of arteriosclerosis.

Joseph Francis O'Brien ✠ Hartford, Conn.; University of Vermont College of Medicine, Burlington, 1913; aged 40; died, April 21, of peritonitis following appendicitis.

Jacob G. Wortman ✠ Mound City, Kan.; Kansas City (Mo.) Medical College, 1900; aged 71; died, April 26, at a hospital in Fort Scott, of gangrenous appendicitis.

James McBurney Moore ✠ Midway, Pa.; Western Reserve University School of Medicine, Cleveland, 1885; aged 64; died suddenly, April 24, of angina pectoris.

Marsden F. R. Irwin, Winnipeg, Man., Canada; University of Manitoba Faculty of Medicine, Winnipeg, 1905; aged 49; died, in April, of cerebral hemorrhage.

William V. Bush, Hadley, Ky.; University of Nashville (Tenn.) Medical Department, 1875; postmaster of Hadley since 1909; aged 78; died, April 29.

John W. Nixon, New Philadelphia, Ohio; Starling Medical College, Columbus, 1879; county coroner; aged 76; died, April 21, of cerebral hemorrhage.

The Propaganda for Reform

IN THIS DEPARTMENT APPEAR REPORTS OF THE JOURNAL'S BUREAU OF INVESTIGATION, OF THE COUNCIL ON PHARMACY AND CHEMISTRY AND OF THE ASSOCIATION LABORATORY, TOGETHER WITH OTHER GENERAL MATERIAL OF AN INFORMATIVE NATURE

[CONTRIBUTION FROM THE CHEMICAL LABORATORY OF THE AMERICAN MEDICAL ASSOCIATION]

EXAMINATION OF SOME LIQUID PETROLATUM AGAR EMULSIONS

L. E. Warren, Ph.C., B.S.

During the last year or two a number of preparations have appeared on the market which are said to be emulsions of liquid petrolatum with agar. In addition to these two constituents the preparations are reported to contain one or more of such substances as acacia, glycerin, phenolphthalein, sucrose, sodium benzoate and soluble saccharin.

Some of these petrolatum agar products were submitted to the Council on Pharmacy and Chemistry of the American Medical Association for inclusion with New and Nonofficial Remedies. As the claims made in regard to the composition of one of these emulsions were questioned, the Council requested the Laboratory to examine the product and to work out, if possible, a method of chemical evaluation of the ingredients. In doing this, the investigation of other market preparations of agar petrolatum emulsions was undertaken. The products analyzed were:

AGAROL COMPOUND: William R. Warner & Co., Inc.

AGRILIN: The Agrilin Co. (Lehn & Fink, Inc., sole distributors, U. S. A.).

SQUIBB'S LIQUID PETROLATUM WITH AGAR: E. R. Squibb & Sons.

PETROLAGAR: Deshell Laboratories, Inc.

TERRALINE WITH AGAR AGAR: The Hillside Chemical Co.

Qualitative tests indicated the presence of agar and liquid petrolatum in each preparation, although the liquid petrolatum obtained from "Terraline with Agar Agar" was highly colored and fluorescent. In addition tests were made for each of the other substances which have been reported as present in the various preparations. No product was found to contain all of them. Substances precipitable by alcohol were present in all. Glycerin and sodium benzoate were found in others. Sucrose was found in one, phenolphthalein in one and saccharin in one. Each of the products was of a white, or pale yellowish-white color, except "Terraline with Agar-Agar," which was of a pale lemon-yellow color. Each was acid to moistened litmus paper. Each had a mildly sweet taste, except "Agrilin," which was nearly tasteless, and "Terraline with Agar Agar," the taste of which was intensely sweet. Some of the preparations appeared to be flavored with vanilla. The findings obtained in the analysis[1] of the several products are given in the accompanying table.

The adult dose recommended for most of these petrolatum-agar preparations is one tablespoonful twice a day, or one fluidounce daily. Calculation from the analyses shows the quantity of agar and liquid petrolatum that the patient gets by taking any of the preparations examined in its recommended dose.

1. After trial of several methods suggested by manufacturers for the determination of liquid petrolatum, this substance was determined by diluting the preparation with water and applying the Roese-Gottlieb method for the determination of fat in milk. (Official and Tentative Methods of Analysis, A. O. A. C., 1919, p. 227.) This method had been suggested by LaWall and Foreman (*J. Am. Pharm. A.* **3**: 144, 1914) for determining fat in emulsions. The details of the analysis will be published in the Annual Reports of the Chemical Laboratory A. M. A., 1925. No very satisfactory method for the determination of agar was found, but after a number of experimental trials a method was employed which was offered by E. R. Squibb and Sons. The method was considered satisfactory for comparative analysis, although the exact limits of accuracy for absolute determination was not investigated. Briefly, this consists in evaporating the residue remaining after the extraction of liquid petrolatum to approximately constant weight and treating the residue with cold water. The insoluble portion is dried and weighed as agar. The filtrate is concentrated by evaporation, and the fraction precipitable by alcohol in the concentrate is considered as "substances precipitable by alcohol." The "alcohol-precipitable substances" may be acacia (or other gums) or possibly may be water-soluble constituents from the agar.

AGAROL COMPOUND

The formula for Agarol Compound is not divulged and no claims for its composition are made except that it contains liquid petrolatum and agar (in unstated amounts) and ¼ grain of phenolphthalein in each teaspoonful. It is claimed to be free from "sugar, saccharine, alkalies, alcohol or hypophosphites." Of the several preparations examined, Agarol Compound is the lowest in content of liquid petrolatum. Possibly its low value in this essential may account for its having been reinforced by phenolphthalein. The recommended dose of Agarol Compound of from one-half to one tablespoonful contains from 15 to 30 per cent. of a U. S. P. dose of liquid petrolatum and from 1½ to 3 grains of phenolphthalein. The U. S. P. dose of phenolphthalein is 2½ grains. Based on the analysis, Agarol Compound contains in each tablespoonful about 1 per cent. of a U. S. P. dose of agar.

AGRILIN

In the report of the Council on Pharmacy and Chemistry refusing Agrilin inclusion with New and Nonofficial Remedies,[2] the composition of the product (in part) as claimed by the manufacturer was given as: liquid petrolatum, 38.6 per cent., and agar, 2.25 per cent. The analysis indicated about 90 per cent. of the claimed amount of liquid petrolatum and about 64 per cent. of the claimed amount of agar. Based on the analysis, each recommended dose of one tablespoonful contains about 37 per cent. of a U. S. P. dose of liquid petrolatum and about 2.5 per cent. of a U. S. P. dose of agar.

Analyses of Some Liquid Petrolatum Agar Emulsions

	Brand				
	Agarol Comp.	Agrilin	Petrolagar	Squibb	Terraline with Agar Agar
Specific gravity, 25/25 C.	1.001	0.984	0.916	0.991	0.983
Loss on drying	53.7	57.6	35.2	34.3	57.1
Liquid petrolatum	27.0	33.2	61.0	44.7	29.8
Specific gravity of liquid petrolatum	0.888	0.870	0.864	0.883	0.896
Residue not petrolatum	18.6	9.1	3.7	21.2	1.6
Agar (by Squibb method)	0.6	1.4	0.3	1.3	0.3
Substances precipitable by alcohol	1.3	5.2	0.6	3.7	0.4
Sodium benzoate	—	0.07	0.1	0.1	—
Phenolphthalein	1.3	—	—	—	—
Glycerin	14.9	1.9	—	14.2	—
Soluble saccharin	—	—	—	—	0.2
Sucrose	—	—	2.2	—	—

PETROLAGAR

At the time of its introduction, Petrolagar was claimed to contain "10 per cent. of prepared agar agar" and 65 per cent. of liquid petrolatum. On the request of the Council on Pharmacy and Chemistry that the Deshell Laboratories make a definite, quantitative declaration of the composition of the product, the firm gave the following figures:

"Liquid Petrolatum U. S. P.	65	c.c.
"Agar U. S. P.	10	gm.
"Sugar and flavoring	2	gm.
"Sodium Benzoate	0.1	gm.
"Water to make	100	c.c."

The analysis did not confirm the latter statement.[3] Based on the results of the analysis, each dose of one tablespoonful contains about 65 per cent. of a U. S. P. dose of liquid petrolatum and less than 1 per cent. of a U. S. P. dose of agar. Petrolagar contains the highest proportion of liquid petrolatum of any of the preparations examined, but is relatively low in agar content.

SQUIBB'S LIQUID PETROLATUM WITH AGAR

Squibb's Liquid Petrolatum with Agar was stated to contain 50 per cent. by volume of liquid petrolatum, 1.5 per cent. of agar, and unstated amounts of acacia and glycerin. These claims were substantially confirmed by the analysis. Each dose of one tablespoonful contains about 50 per cent. of a U. S. P. dose of liquid petrolatum and about 2.25 per cent. of a U. S. P. dose of agar.

TERRALINE WITH AGAR-AGAR

No claims are made for the composition of Terraline with Agar-Agar except that it is "petroleum purificatum with agar-agar." The petrolatum separated from the preparation in the analysis was not colorless, like the liquid petrolatum from the other preparations examined, but it was colored brownish yellow and possessed a marked fluorescence like lubricating oil. The petrolatum in Terraline with Agar-Agar chemically cannot be considered liquid petrolatum of U. S. P. quality. Each recommended dose of the preparation of from one to two teaspoonfuls contains petrolatum equivalent in quantity to from 11 per cent. to 22 per cent. of a U. S. P. dose of liquid petrolatum. A dose of the preparation contains from 0.12 to 0.24 per cent. of a U. S. P. dose of agar. The preparation is sweetened with saccharin.

SUMMARY

The examination reveals that the market preparations of liquid petrolatum with agar vary widely in their content of liquid petrolatum (from 27 to 61 per cent.) and considerably in their agar content. The largest amount of agar in any of the specimens examined was equivalent to about 1.5 per cent. of agar U. S. P.

2. THE JOURNAL A. M. A. 84:837 (March 14) 1925.
3. Since the analysis of Petrolagar was made, the firm has informed the Council that the product now being marketed contains 1¼ per cent. of agar U. S. P.

Correspondence

PENNSYLVANIA PROTESTS NEW JERSEY DISCRIMINATION

To the Editor:—The states of Pennsylvania and New Jersey both require a year spent in an approved hospital as an intern before a candidate can present himself for examination in order to obtain a license to practice medicine.

The Pennsylvania Board of Medical Examiners refused to consider a certain hospital in New Jersey as on its approved list although the New Jersey board considered this hospital as a satisfactory hospital for intern service and placed it on its list of approved hospitals.

The New Jersey board, then becoming annoyed at the Pennsylvania board because it would not approve this hospital, has blacklisted every hospital in the state of Pennsylvania, as is apparent from a letter which I have just received under date of May 7, 1925, which reads as follows:

> The board at a meeting held today decided that until the Pennsylvania board recognizes the rating accorded New Jersey hospitals by this board, based on the ratings of the American College of Surgeons, they could not recognize an internship served in a Pennsylvania hospital.

In June, 1923, Dr. Ralph K. Bush, whose home is in New Jersey, graduated from the University of Pennsylvania School of Medicine, and accepted an intern service of two years in duration at the Episcopal Hospital in Philadelphia. This is one of the best hospitals in Philadelphia. Dr. Bush did this in perfect confidence that, on the completion of his intern service, he would be able to take the examination for licensure in the state of New Jersey, in which state he expected to practice. He did so with my knowledge and under my advice.

As Dr. Bush's service will terminate on the first of June next, a few days ago he made application to the New Jersey board and sent it the customary $25 to cover the fee for the examination. The secretary of the New Jersey board, under date of May 8, has written the following letter to Dr. Bush:

> The board on May 7 decided that until Pennsylvania recognizes the rating accorded New Jersey hospitals by this board, based on the rating of the American College of Surgeons, they could not recognize an internship served in a Pennsylvania hospital.
>
> Therefore, before you can be admitted to the examination in this state, it will be necessary for you to furnish evidence of having completed a year's internship in an approved hospital outside of the state of Pennsylvania.

We are enclosing check for twenty-five dollars to cover fee submitted with your application.

Apparently because of this row between the two boards, Dr. Bush, despite his two years of intern service spent in an excellent hospital, will now have to spend another year in some hospital approved by the New Jersey board outside Pennsylvania before he can take the licensing examination in New Jersey. Presumably, other young men will be made to suffer in the same way if this ruling of the New Jersey board is permitted to stand.

As the dean of a medical school and a member of the Council on Medical Education and Hospitals of the American Medical Association, I wish to place myself on record as objecting strenuously to such rulings by state boards of medical examiners. This action of the New Jersey board, which in my opinion can be explained only as a retaliation on another board, reacts unfairly and unjustly on recent graduates who in all good faith during the past year or two have been, as they thought, meeting in every way the New Jersey requirements.

I trust that others will join with me in objecting to this arbitrary ruling of the New Jersey board.

WILLIAM PEPPER, M.D., Philadelphia.
Dean, University of Pennsylvania
School of Medicine.

THE IMPROVED CANNULA AND TROCAR

To the Editor:—The paper by Dr. Bryce W. Fontaine (THE JOURNAL, April 18, p. 1179) interested me. During the summer of 1914, it became necessary for me to spend some days in the Lewis-Gale Hospital, Roanoke, Va. While there, Dr. S. S. Gale showed me a cannula and trocar he had devised and had made by Tiemann of New York, with holes in the sides of the cannula as shown in the illustration of Dr. Fontaine's cannula. I told Dr. Gale that when I came again to the hospital I would bring him a book more than a hundred years old in which was a description and an illustration of a cannula with holes just as in his instrument. Dr. Gale now owns this book, the title of which is "A Treatise on Surgery," by Samuel Sharp, surgeon to Guy's Hospital, London, Edition 10, printed in London in 1782. The illustration of this instrument is shown on page 65 of the book, with a full description.

Some time later, Dr. George B. Lawson of Roanoke, Va., wrote me that he had devised a flat cannula and trocar having a sharp or lancet-like point, as being more applicable and more easily introduced in certain conditions. I found in Bell's Surgery, printed in Edinburgh **2**:184, 1790, Plate XXI, just such a flat instrument as Dr. Lawson had invented. This plate shows a trocar and cannula of the usual round form with a triangular point, but with a deep groove in the trocar, or "perforator," commencing at the point and continuing through the whole of it. This "serves to point out with much certainty its entrance into the bladder; for the urine is observed to flow along this groove immediately on the point of it having entered the bladder."

In those bygone days the operation of tapping the bladder above the pubis was not infrequently resorted to of necessity. This operation, together with wearing inserted in the bladder a short, slightly curved tube rounded at the end, with holes in the side, and eyelets into which tapes were inserted to hold it in place, and a cork to control the flow of urine, seems to have met with quite a degree of surgical favor (Bell's Surgery and Parrish's Practical Observations, pp. 248-261). Dr. Parrish was a pupil and protégé of Dr. Physick, and his book was published in Philadelphia in 1836.

S. W. DICKINSON, M.D., Marion, Va.

Queries and Minor Notes

ANONYMOUS COMMUNICATIONS and queries on postal cards will not be noticed. Every letter must contain the writer's name and address, but these will be omitted, on request.

ROENTGEN-RAY EVIDENCE OF PREVIOUS FRACTURE

To the Editor:—Can we determine by roentgen-ray examination that a bone has previously been broken? Does the bone always show evidence of previous fracture? If an adult had a Colles' fracture eight years ago, would the roentgenogram show any evidence of this?

R. I. STEWART, M.D., Lindstrom, Minn.

ANSWER.—It is recognized that a fractured bone having little or no displacement may restore completely its original structure, but it is rather unusual with any deformity or impaction to obtain a perfect alinement. Other evidence of fracture may result, such as thickening or new bone formation from torn periosteum. However, with imperfectly reduced, comminuted or impacted fractures it may be difficult to diagnose their previous existence after a lapse of several years. This may be due to four conditions:

1. There may be a variation from normal in the outline and structure of the same bone in different persons, or in the right and left sides of the same person. Madelung has described a deformity of the lower end of the radius which may be congenital.

2. There may be a lack of uniformity in roentgenograms. Views should be made of both arms from all angles, for comparison. The films should permit interpretation of the arrangement of bone trabeculae and slight irregularities of outline and density.

3. The correction of deformity by bone growth is commonly present in children, though rare in older persons. Truesdell observed a progressive elimination of deformity in fractures which was especially striking in unreduced dislocations of the epiphysis of long bones. He has observed formation of a new shaft, from subperiosteal callus, and of new femoral condyles with absorption of the old. He believes that the decrease in deformity after fractures follows the same physiologic laws as development of the ribs in utero; that is, a deposit of new bone on one side and absorption on the other.

4. A variation in the lower end of the radius may be the result of some injury other than a Colles' fracture, of new growth, or of inflammation. Fracture of the lower end of the radius is rare before puberty, while an epiphyseal separation is quite common.

LACTODEXTRIN AND THE INTESTINAL FLORA

To the Editor:—What is the cause and treatment of fecal smelling eructations? Lactodextrin is advertised to cure by changing the intestinal flora. Is this anything more than a fine theory? Should meat be entirely eliminated from the diet? Please omit my name.

H. H., M.D., Massachusetts.

ANSWER.—Foul smelling eructations are due to putrefactive decomposition within the alimentary tract, possibly with reverse peristalsis. A thorough gastro-intestinal examination, including test meal and stool examination, as well as roentgenologic study of the alimentary tract, should be resorted to to serve as a basis for intelligent prescribing. A low protein diet is likely to be indicated in such a case, and elimination of meat from the diet is one method of prescribing such a diet. Increase in carbohydrate ingestion has been shown to lessen protein decomposition in the bowel; and carbohydrate may be increased in the diet by the use of lactodextrin (a mixture of lactose and dextrin) or lactose, or an abundance of bread.

SERUM RING REACTION

To the Editor:—Will you kindly furnish me with complete information as to what the ring test is and how used? I understand that it is used in activity tests for tuberculosis and is somewhat similar to the Wassermann blood test.

F. E. NAGEL, M.D., Chicago.

ANSWER.—The serum ring test was described by Smeeton (*Am. Rev. Tuberc.* **6**:588 [Sept.] 1922). It is not a complement fixation test like the Wassermann reaction. Smeeton placed 0.3 c.c. of the patient's serum in a test tube and floated over it 0.3 c.c. of a 1:100 dilution of old tuberculin. The

formation of a thin, opaque, disklike ring between the two fluids was interpreted as a positive reaction. Usually the ring formed in ten minutes, and in some cases it could be seen more clearly after two or three hours. Smeeton obtained positive reactions more frequently in tuberculous persons than in normal ones, but did not find the reaction specific.

Medical Education, Registration and Hospital Service

COMING EXAMINATIONS

ALABAMA: Montgomery, July 13. Ch., Dr. Samuel W. Welch, Montgomery.
ARIZONA: Phoenix, July 7-8. Sec., Dr. W. O. Sweek, 404 Heard Bldg., Phoenix.
CALIFORNIA: Los Angeles, June 15-18. Sec., Dr. Charles B. Pinkham, 906 Forum Bldg., Sacramento.
CALIFORNIA: San Francisco, July 6-9. Sec., Dr. Charles B. Pinkham, 906 Forum Bldg., Sacramento.
COLORADO: Denver, July 7. Sec., Dr. David A. Strickler, 612 Empire Bldg., Denver.
CONNECTICUT: Hartford, July 14-15. Sec., Reg. Bd., Dr. Robert L. Rowley, 79 Elm St., Hartford.
CONNECTICUT: New Haven, July 14. Sec., Homeo. Bd., Dr. Edwin C. M. Hall, 82 Grand Ave., New Haven.
DELAWARE: Wilmington, June 16-18. Sec., Reg. and Homeo. Bd., Dr. H. W. Briggs, 1026 Jackson St., Wilmington.
DISTRICT OF COLUMBIA: Washington, July 14. Sec., Dr. Edgar P. Copeland, Stoneleigh Court, Washington.
FLORIDA: Tampa, June 15-16. Sec., Dr. William M. Rowlett, Citizens Bank Bldg., Tampa.
GEORGIA: Augusta, June 2-4. Sec., Dr. C. T. Nolan, Marietta.
GEORGIA: Atlanta, June 10-12. Sec., Dr. C. T. Nolan, Marietta.
HAWAII: Honolulu, July 13. Sec., Dr. G. C. Milnor, 401 S. Beretania St., Honolulu.
ILLINOIS: Chicago, June 23-25. Supt. of Regis., Mr. V. C. Michels, Springfield.
INDIANA: Indianapolis, July 14-16. Sec., Dr. W. T. Gott, 333 State House, Indianapolis.
IOWA: Iowa City, June 4-6. Sec., Dr. Rodney P. Fagen, Capitol Bldg., Des Moines.
KANSAS: Kansas City, June 16. Sec., Dr. Albert S. Ross, Sabetha.
KENTUCKY: Louisville, June 9-11. Sec., Dr. A. T. McCormack, State Board of Health Bldg., Louisville.
LOUISIANA: New Orleans, June 11-13. Sec., Red. Bd., Dr. Roy B. Harrison, 1507 Hibernia Bank Bldg., New Orleans.
MAINE: Augusta, July 7-8. Sec., Dr. Adam P. Leighton, Jr., 192 State St., Portland.
MARYLAND: Baltimore, June 16-19. Sec., Reg. Bd., Dr. Henry M. Fitzhugh, 1211 Cathedral St., Baltimore.
MARYLAND: Baltimore, June 9-10. Sec., Homeo. Bd., Dr. J. S. Garrison, Ten Hills, Baltimore.
MICHIGAN: Ann Arbor, June 9-11. Acting Sec., Dr. Guy L. Connor, 707 Stroh Bldg., Detroit.
MICHIGAN: Detroit, June 15-17. Sec. Dr. Guy L. Connor, 707 Stroh Bldg., Detroit.
MINNESOTA: Minneapolis, June 16-18. Sec., Dr. Thomas S. McDavitt, Lowry Bldg., St. Paul.
MISSISSIPPI: Jackson, June 23-24. Sec., Dr. F. J. Underwood, Jackson.
MISSOURI: St. Louis, June 23-26. Sec., Dr. James Stewart, Capitol Bldg., Jefferson City.
NATIONAL BOARD OF MEDICAL EXAMINERS: Written examinations in Class A medical schools. Parts I and II, June 24-26. All applications for this examination must be made on or before June 1. Sec., Dr. J. S. Rodman, 1600 Walnut St., Philadelphia.
NEBRASKA: Omaha, June 8-10. Supt., Dr. W. H. Wilson, Lincoln.
NEW JERSEY: Trenton, June 16-17. Sec., Dr. Alexander Macalister, State House, Trenton.
NEW YORK: Albany, Buffalo, New York and Syracuse, June 22-25. Sec., Dr. Harold Rypins, Education Bldg., Albany.
NORTH CAROLINA: Raleigh, June 22-26. Sec., Dr. Kemp P. B. Bonner, Morehead City.
NORTH DAKOTA: Grand Forks, July 7. Sec., Dr. George M. Williamson, 860 Belmont Ave., Grand Forks.
OHIO: Columbus, June 9-12. Sec., Dr. H. M. Platter, Hartman Hotel Bldg., Columbus.
OKLAHOMA: Oklahoma City, June 16-17. Sec., Dr. James M. Byrum, Shawnee.
OREGON: Portland, July 7-9. Sec., Dr. Urling C. Coe, Stevens Bldg., Portland.
PENNSYLVANIA: Philadelphia and Pittsburgh, July 7-11. Sec., Dr. J. George Becht, State Capitol, Harrisburg.
RHODE ISLAND: Providence, July 2-3. Dr. Byron W. Richards, State House, Providence.
SOUTH CAROLINA: Columbia, June 23. Sec., Dr. A. Earle Boozer, 906 Forum Bldg., Sacramento.
TENNESSEE: Knoxville, Memphis and Nashville, June 12-13. Sec., Dr. Alfred B. DeLoach, 434 Madison Ave., Memphis.
TEXAS: Austin, June 23-25. Sec., Dr. T. J. Crowe, 918-19 Mercantile Bank Bldg., Dallas.
UTAH: Salt Lake City, July 7. Dir. of Regis., Mr. J. T. Hammond, 412 State Capitol Bldg., Salt Lake City.
VERMONT: Burlington, June 24-26. Sec., Dr. W. Scott Nay, Underhill.
VIRGINIA: Richmond, June 23-26. Sec., Dr. J. W. Preston, Shenandoah Life Bldg., Roanoke.
WASHINGTON: Olympia, July 6. Sec., Mr. William Melville, Olympia.
WEST VIRGINIA: Martinsburg, July 7. Sec., Dr. W. T. Henshaw, Charleston.
WISCONSIN: Milwaukee, June 30, July 1-2. Sec., Dr. Robert E. Flynn, 315 State Bank Bldg., La Crosse.
WYOMING: Cheyenne, June 8-10. Sec., Dr. J. D. Shingle, Citizens Bank Bldg., Cheyenne.

SCHOOLS OFFERING SUMMER COURSES, 1925

Alabama

UNIVERSITY OF ALABAMA SCHOOL OF MEDICINE, Tuscaloosa.—Courses designed for medical students and others qualified to take them. Classes limited to forty students in each subject. Summer quarter divided into two terms. First term begins, June 3, and ends, July 14. Second begins, July 15, and ends, August 18. Instruction will be given in anatomy, bacteriology, physiologic chemistry and surgery. Dr. Clyde Brooks, dean.

California

UNIVERSITY OF CALIFORNIA MEDICAL SCHOOL, San Francisco.—Courses for qualified graduates in medicine, given in general medicine, pediatrics, gastro-intestinal diseases, dermatology, syphilology, radium therapy, general surgery, orthopedic surgery, otorhinolaryngology, ophthalmology, genito-urinary diseases, surgical pathology, roentgen ray, obstetrics and gynecology, circulatory diseases, laboratory diagnosis, neurology and neuropsychiatry. Summer term begins, June 15, and ends, July 11. Dr. L. S. Schmitt, acting dean.

STANFORD UNIVERSITY SCHOOL OF MEDICINE, San Francisco.—Courses designed for qualified graduates in medicine and medical students of this and other schools. Opportunities for clinical and laboratory work. Special workers received in pharmacology, pathology, general medicine, electrocardiography and basal metabolism, chest diseases, pediatrics, neuropsychiatry, skin and syphilis, metabolism laboratory, radiology, physiotherapy, general surgery, orthopedic surgery, genito-urinary surgery, ophthalmology, otorhinolaryngology, surgical pathology, obstetrics and gynecology and female urology. Summer term begins, June 15, and ends, September 1. Dr. William Ophuls, dean.

Colorado

UNIVERSITY OF COLORADO SCHOOL OF MEDICINE, Denver.—Courses open for undergraduate or graduate students, in anatomy, bacteriology, biochemistry, pathology, clinical pathology, physiology and pharmacology. Summer session divided into two terms. The first begins, June 22, and ends, July 27; the second begins, July 28, and ends, August 28. Dr. Charles N. Meader, dean.

District of Columbia

GEORGE WASHINGTON UNIVERSITY MEDICAL SCHOOL, Washington.—Courses offered for medical students in pathology, bacteriology, clinical microscopy and parasitology. Registration begins, June 11. Dr. W. C. Borden, dean.

HOWARD UNIVERSITY SCHOOL OF MEDICINE, Washington.—Courses open to graduates of recognized medical colleges. Instruction given in general surgery, gynecology, genito-urinary surgery, internal medicine, otolaryngology, ophthalmology, roentgenology, public health, laboratory methods and physical diagnosis. Summer term begins, June 8, and ends, July 18. Dr. Edward A. Balloch, dean.

Illinois

RUSH MEDICAL COLLEGE, Chicago.—Summer courses offered to graduates in medicine and medical students, in zoology, anatomy, physiology, physiologic chemistry and pharmacology, pathology, hygiene and bacteriology, medicine, pediatrics, surgery, obstetrics and gynecology, laryngology and otology, ophthalmology and dermatology. Terms are from June 22 to July 29, and from July 30 to September 4. Dr. Ernest E. Irons, dean.

Indiana

INDIANA UNIVERSITY SCHOOL OF MEDICINE, Indianapolis.—Postgraduate courses offered to qualify physicians during six week period, June 11 to July 23, in pathology, pharmacology, medicine, surgery, gynecology, genito-urinary diseases, rhinology, otology, laryngology, ophthalmology, dermatology and syphilology. A course in biochemistry and bacteriology will be given provided there are enough applicants. These subjects are equivalent to the second year's work. Further information may be obtained through the registrar.

Iowa

STATE UNIVERSITY OF IOWA COLLEGE OF MEDICINE, Iowa City.—Courses are offered in surgical specialties and in anatomic subjects, bacteriology and physiology. Courses designed both for review and for work preliminary to the regular medical courses in those subjects. Term begins, June 15, and ends, August 28. Dr. Lee Wallace Dean, dean.

Kansas

UNIVERSITY OF KANSAS SCHOOL OF MEDICINE, Lawrence-Kansas City.—Courses for medical students offered at Lawrence in physiology, bacteriology and immunology, and at Kansas City in pathology. Dr. H. R. Wahl, acting dean.

Louisiana

TULANE UNIVERSITY SCHOOL OF MEDICINE, New Orleans.—Courses offered for medical students in anatomy, embryology, histology, neuranatomy, physiologic chemistry, dermatology, special pathology and physical diagnosis. All courses begin, June 15, and continue for a period of six weeks, ending, July 25. Dr. C. C. Bass, dean.

Maryland

UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE, Baltimore.—A review course for physicians from June 1 to June 27. Courses not planned, nor will they enable the practitioner to become a specialist, but are for those who wish to review the fundamental data in some field, and to inform themselves concerning recent advances in methods of diagnosis and treatment. Dr. J. M. H. Rowland, dean.

Massachusetts

HARVARD UNIVERSITY MEDICAL SCHOOL, Boston.—Courses for graduates open from June 1 to September 30 in anatomy, physiology, biologic chemistry, bacteriology, pathology, preventive medicine and hygiene. The usual work in all medical subjects is offered throughout the entire year. Dr. Samuel R. Meaker, secretary.

Michigan

UNIVERSITY OF MICHIGAN MEDICAL SCHOOL, Ann Arbor.—Courses open to undergraduate students and practitioners of medicine in anatomy, bacteriology, dermatology and syphilology, homeopathic materia medica, internal medicine, obstetrics and gynecology, pathology, pharmacology, physiologic chemistry, physiology, roentgenology, surgery and also courses for technicians. Courses begin, June 22, and end, July 21. Dr. Hugh Cabot, dean.

DETROIT COLLEGE OF MEDICINE AND SURGERY, Detroit.—Private course in gross anatomy and lectures and demonstrations on physiotherapy open to graduates in medicine. Fees go into a fund for needy students. The courses mentioned will have no credit value. Dr. W. H. MacCraken, dean.

Minnesota

UNIVERSITY OF MINNESOTA MEDICAL SCHOOL, Minneapolis.—Courses open to undergraduate students and physicians in anatomy, bacteriology, pathology, pharmacology, physiology, preventive medicine and public health, medicine, obstetrics and gynecology, ophthalmology and otolaryngology, pediatrics, surgery and roentgenology. Two terms, extending from June 19 to August 1, and from August 3 to September 5. Students may attend either or both terms. Dr. Elias P. Lyon, dean.

Missouri

ST. LOUIS UNIVERSITY SCHOOL OF MEDICINE, St. Louis.—Work adjusted to needs of three classes of students:

1. Undergraduate medical students. Courses in laboratory branches for students who desire to secure advanced standing or to remove conditions. Open to both practitioners and undergraduates.

2. Preparatory and collegiate medical students. Courses in biology, inorganic and organic chemistry, physics and language offered for students who lack sufficient college credit to qualify for admission to medical school.

3. Teachers, etc. High school teachers and others who possess the required preliminary training but who do not care for credit in medicine will be admitted to the laboratory and other courses.

Session extends from June 1 to July 25. Director of the Summer School, 1402 South Grand Boulevard, St. Louis.

UNIVERSITY OF MISSOURI SCHOOL OF MEDICINE, Columbia.—Summer courses open to students of the university and designed especially for teachers and those desiring to obtain the teacher's certificate, in the departments of medical bacteriology and preventive medicine, from June 6 to August 1. Dr. Guy L. Noyes, dean.

Nebraska

UNIVERSITY OF NEBRASKA COLLEGE OF MEDICINE, Omaha.—Courses offered in physiology and clinical pathology, beginning June 1. Apply to the registrar.

New York

COLUMBIA UNIVERSITY COLLEGE OF PHYSICIANS AND SURGEONS, New York.—Courses for medical students, offered from July 1 to August 15 in anatomy, bacteriology, cancer research, neurology, practice of medicine and midwifery. Courses for graduates in medicine in medical diagnosis and pathology, from June 1 to July 10; in medicine, public health and preventive medicine, from July 6 to August 14; in dermatology and syphilology through the summer and academic year 1925-1926; in internal medicine, from June 8 to July 17; in gastro-enterology (lectures, laboratory and clinical work), July and August; in neurology, from July 1 to August 15. Dr. William Darrach, dean.

UNIVERSITY OF BUFFALO MEDICAL DEPARTMENT, Buffalo.—Summer course in chemistry, for graduates and students, from June 1 to August 1. Dr. C. Sumner Jones, dean.

Ohio

OHIO STATE UNIVERSITY COLLEGE OF MEDICINE, Columbus.—Courses for undergraduate and graduate students in anatomy, bacteriology, chemistry, medicine and clinical medicine, obstetrics and surgery. Summer quarter extends from June 22 to September 4. Dr. Eugene F. McCampbell, dean.

UNIVERSITY OF CINCINNATI COLLEGE OF MEDICINE, Cincinnati.—Courses in biochemistry, physiology and bacteriology, open to undergraduates and physicians, extend from June 15 to August 8. Dr. A. C. Bachmeyer, dean.

WESTERN RESERVE UNIVERSITY SCHOOL OF MEDICINE, Cleveland.—Courses in physiology, histology and embryology offered to undergraduates for make-up work. Courses not given unless a certain number apply. Students from other schools admitted when feasible. Dr. Carl A. Hamann, dean.

Oklahoma

UNIVERSITY OF OKLAHOMA SCHOOL OF MEDICINE, Oklahoma City.—Two advanced courses during June and July in modern analytic methods of biochemistry and pharmacology for physicians and others properly qualified. For details write to Prof. M. R. Everett.

Texas

UNIVERSITY OF TEXAS SCHOOL OF MEDICINE, Galveston.—Summer clinics in all clinical subjects, including ward cases, obstetric practice and outpatient clinics, open to students of the medical school of the University of Texas. Dr. William Keiller, dean.

Utah

UNIVERSITY OF UTAH SCHOOL OF MEDICINE, Salt Lake City.—Courses for undergraduate and graduate students in bacteriology, chemistry and hygiene and public health during the summer terms from June 10 to July 22, and July 27 to August 29. Dr. Ralph O. Porter, dean.

West Virginia

UNIVERSITY OF WEST VIRGINIA SCHOOL OF MEDICINE, Morgantown.—Courses offered to undergraduate students in anatomy, both gross and miscroscopic, including neurology and embryology, physiologic chemistry and bacteriology, during summer of 1925. Dr. John N. Simpson, dean.

Wisconsin

UNIVERSITY OF WISCONSIN MEDICAL SCHOOL, Madison.—Summer courses open to undergraduate students from June 29 to August 7 in anatomy, bacteriology, clinical medicine, pharmacology, physiologic chemistry and physiology. Dr. Charles R. Bardeen, dean.

Book Notices

DISEASES OF THE RECTUM AND PELVIC COLON. By Martin L. Bodkin, M.D., F.A.C.S., Rectal Surgeon, St. Catherine's Hopital. Second edition. Cloth. Price, $6. Pp. 487, with 112 illustrations. New York: E. B. Treat & Company, 1925.

The first edition of this work (1913) was such an indifferent production that it seems incredible that another should be called for. There are the same faults—poor arrangement, diseases of the pelvic colon being jumbled up with those of the rectum and anus; incompleteness, foreign bodies in the rectum being included, but not wounds or ruptures; unevenness, sixty-two pages being allotted to operative treatment of malignant tumors, seven in the form of a quotation. Another eight-page quotation occurs in the chapter on hemorrhoids. We find no evidence for the statement in the preface that "the older material on operations and treatment of malignant disease, as well as the book throughout, have received careful revision." Thus, Bacon's operation for entero-anastomosis by a button in rectal stricture is resurrected after a sleep of thirty-odd years. It seems that undue reliance is placed on the technic of the late J. P. Tuttle. In his day this author was facile princeps, no doubt; but in the thirteen years elapsing since his untimely death, much progress has been made, notably in the technic of interventions for carcinoma. While a disclaimer is made that "irrelevant subjects" have been excluded, surely the five pages on diseases of the coccyx are not germane to the scope of the work. (Postanal dimples, by the way, have no relation to such diseases.) The final twelve pages are occupied by formulas, thirty for hemorrhoids, and twenty-seven for pruritus. Much more satisfactory single volume works on this subject have appeared recently in this country.

L'INNERVATION PÉRIPHÉRIQUE. Exposé succinct de l'origine, du trajet et de la distribution des nerfs craniens et rachidiens ainsi que des nerfs du système sympathique et aperçu des phénomènes pathologiques les plus importants. Par le Dr. Emile Villiger, Professeur E. O. à l'Université de Bâle. Traduction française par le Dr. Pierre Hoff, Chef des travaux anatomiques à l'Université de Genève. Third edition. Paper. Price, 22 francs. Pp. 214, with 66 illustrations. Paris: E. Le François, 1924.

This will be found, as stated by the publishers, to be useful to students and practitioners alike. The origin, pathways and distribution of the cranial and spinal nerves are comprehensively described, as well as the sympathetic nervous system. Although perhaps more properly belonging to some other chapter on anatomy, considerable attention is paid to lesions of the corticospinal tract, paralyses and hyperkineses. Not only is the pathology of the peripheral sensory nerves described, but interference with function of their intraspinal pathways is noted. Some space is devoted to disturbances of reflexes, but the localization of their levels is unfortunately omitted. The description of the anatomy of the cranial nerves is complete, yet succinct. The facial and trigeminal nerves and their ganglions are particularly well outlined. In the part dealing with the spinal nerves, prominent attention is paid to the function of each nerve, and the tables illustrating the action of muscles are clear. Although no specific reference is made to protagonists or supplementary muscles, the physiology of the peripheral nerves is very satisfactory. The chapter on the sympathetic nervous system is clear, complete and well illustrated. The brief descriptions of the clinical signs of injury or disease of the peripheral nerves, although incomplete and more or less stereotyped, serve to fix the attention of the student, increase his interest, and make the reception of anatomic knowledge more palatable. The anatomic diagrams are excellent, and the illustrations of the clinical cases fairly satisfactory.

IIIe CONFÉRENCE INTERNATIONALE DE LA LÈPRE. Strasbourg—28 au 31 Juillet 1923. Recueillis et colligés par Le Dr. E. Marchoux, Professeur à l'Institut Pasteur. Cloth. Pp. 528, with 93 illustrations. Paris: J. B. Baillière et Fils, 1924.

The researches and observations of leprologists of the entire world have in part been recorded in this book. It is a treatise on leprosy edited by the cooperation of all members of the Third International Leprosy Conference. There are chapters on etiology, pathology, treatment, prophylaxis, statistics and legislation, as well as three indexes making the various documents easy to find. Marchoux of the Pasteur Institute, Paris, general secretary of the conference, who collected these discussions, is grateful to members of the conference and to the French government for supplying funds with which to publish these transactions. This volume will be most useful to those who make a special study of leprosy. A small number of copies were printed, and the profits from the sale, it is hoped, will constitute a fund to make possible the publication of the international review, *Lepra*, which was discontinued during the World War.

THE EXAMINATION OF WATERS AND WATER SUPPLIES. By John C. Thresh, D.Sc., M.D., D.P.H., Consulting Medical Officer of Health, Essex County Council, and John F. Beale, B.A., M.R.C.S., L.R.C.P., Bacteriologist to the Essex and Herts County Councils. Third edition. Cloth. Price, $7.50. Pp. 590, with 59 illustrations. Philadelphia: P. Blakiston's Son & Co., 1925.

This book contains much information of interest and value, but it is far from being a complete and accurate picture of the present state of opinion and practice of sanitary water examination. The paragraph on iodin in water, page 153, and the paragraph on page 444 on American methods of bacterial water examination are good examples of the inadequate and sometimes inaccurate handling of the subject treated. On page 444 it is stated that the bacteriologic test generally applied in the United States "is to add 1 c.c. of the water to be examined to each of ten tubes of phenolated broth or of bile-salt glucose broth." The Standard Methods of Water Analysis published by the American Public Health Association is not mentioned, and there is no reference to the "Treasury Standard" of interpretation. Altogether, while American workers in this field will find something of value, they will also find much to wonder at in the way of omission.

THE USE OF FISH FOR MOSQUITO CONTROL. Paper. Pp. 120, with 65 illustrations. New York: International Health Board of the Rockefeller Foundation, 1924.

This is a brief digest of information found readily accessible in New York libraries on the use of fish for mosquito control. It does not pretend to be complete, and the International Health Board would like to be informed of important articles not covered or included in the bibliography that concludes this publication. Information gleaned from correspondence and unpublished reports on file in the office of the board has been added, as well as suggestions and criticisms by specialists in this field. It is not a critical review, however. The reader must decide how much weight should be given to the views of each writer. There is an alphabetical list of the kinds of fish mentioned in the text, with page references, and numerous pictures of fish used in mosquito control.

CONSULTATIONS DU MÉDECIN PRATICIEN. Guide de pratique médico-chirurgicale journalière. Par Le Dr. Fred. Blanchod. Paper. Price, 35 francs. Pp. 584. Paris: J.-B. Baillière et Fils, 1925.

We have here a handy reference book covering practically the whole domain of everyday medical practice, including surgery, obstetrics, gynecology, dermatology and other specialties. The discussion of each subject is necessarily limited to the most important practical points; but the essentials are quite well handled. The book might be of inetrest to the American physician for comparison between our methods and those employed in France.

MEDI-CULT. The A-B-C of the Medical Profession. By B. F. Lorance, M.D. Cloth. Price, $1.50. Pp. 73, with 16 illustrations. Boston: Richard G. Badger, 1924.

The author has attempted in a brief space to give the public the elementary facts regarding the bases of various cults practicing the healing of disease. Such arguments as he presents are sound, but not particularly attractive in their form of presentation. The work contains also a section on the germ theory of disease, with brief, elementary statements as to the various organisms that cause disease.

Medicolegal

Roentgenogram Identified and Interpreted by Deposition

(Demopolis Telephone Company v. Hood (Ala.), 102 So. R. 35)

The Supreme Court of Alabama says that in this personal injury case a roentgenogram was admitted in evidence for plaintiff Hood. The evidence as to the taking of the roentgenogram and what its reading disclosed was by deposition. This testimony tended to show that the roentgenogram was taken by a qualified expert; that it was read by the witnesses qualified by experience and training to do so, and that it disclosed a fracture of the second lumbar vertebra. Objection was made to the roentgenogram as evidence on two grounds: (1) that it was not sufficiently identified as the roentgenogram so taken and testified about by the witnesses, and (2) that the reading of a roentgenogram is the work of an expert —a jury cannot read it, and it should be admitted in evidence only along with the testimony of a competent reader of such roentgenograms, pointing out to the jury the features showing the injury in question. But the taker of the roentgenogram testified to an identifying number placed by him on it, with the date. The roentgenogram was made part of the record. An examination disclosed the number "490," and "6-4-23," standing for June 4, 1923. These marks, in connection with the testimony, were sufficient on the question of identification.

Members of this court, with the aid of such background of light, and probably with about the same skill available to the jury, examined the roentgenogram, but could not, without aid, discover with any assurance the particular appearances indicating the fracture testified to by the expert witnesses, and were persuaded that roentgenograms may be much more valuable evidence when explained to the jury from the stand by a person skilled in reading them, giving the angle at which they were produced, and the special appearance of the part involved indicating injury or not. This court thinks, however, that this roentgenogram was admissible in evidence in connection with the expert testimony given by deposition. At least, it showed there was a roentgenogram giving, with all the accuracy of nature's laws, certain outlines. This fact was a circumstance from which an inference might be drawn favorable to the opinion given by those entirely familiar with the details of the human anatomy, and skilled in detecting injuries thereto by making and reading such roentgenograms. Any inability of the jury to discover unaided the evidences testified to by the experts would probably weaken the probative effect of the roentgenogram with the jury, and work no injury to the defendant.

Physician, Not Hospital, Liable for Burning Patient

(Kuglich v. Fowle et al. (Wis.), 200 N. W. R. 648)

The Supreme Court of Wisconsin says that this action was brought against a physician and a hospital to recover damages for the plaintiff's being burned while in the hospital under the physician's care. The physician, called to the patient's home, found her ill of uremic poisoning and had her removed to the hospital. There she was put to bed and packed with hot water bottles to induce perspiration. Two of the bottles were placed on either side of her, and a fifth between her legs, while she was in an unconscious condition. The bottles were wrapped in blankets. The nurses of the hospital assisted the physician in wrapping the bottles placed at the patient's sides, but the physician wrapped the fifth bottle, which afterward became unwrapped and burned the patient. The jury found that the physician failed to exercise ordinary care in wrapping that bottle, which failure was a proximate cause of the injury. The jury returned a verdict in her favor, on which a judgment was rendered against the defendants—a judgment here affirmed as against the physician, but reversed, with instructions to dismiss the complaint, as to the hospital.

The defendant physician pointed out that on the trial certain physicians testified, as experts, that it was entirely possible for the patient, though unconscious, to unclasp subconsciously the safety pin with which the wrappings of the bottle were fastened. It was contended that this gave rise to two equally plausible theories of the cause of the injury, one being that the blanket was negligently fastened, and the other, that the blanket became unfastened because the plaintiff subconsciously unclasped the safety pin, thus bringing about a situation wherein a jury could do no more than guess concerning the real cause of the injury. But the evidence in this case was very persuasive that the bottle became unwrapped because it was negligently fastened in the first place, and the remote and rather fanciful possibility arising from the testimony of the physicians that in their opinion the plaintiff might subconsciously have unclasped this particular safety pin was not sufficient to introduce a situation within the doctrine sought to be applied.

The liability of the hospital was predicated on the fact that it was the duty of the nurses to wrap the bottles, and that the hospital was responsible for the negligent wrapping. It was conceded, however, that the nurses had nothing to do with wrapping this particular bottle. True, the defendant physician was an officer of the corporation which owned the hospital, and was the real manager thereof. However, on this occasion he was the physician of the plaintiff. The nurses in attendance were not only under his direction as the plaintiff's physician, but, so far as this particular bottle was concerned, he discharged the nurses and the hospital of any duty with respect thereto by wrapping it himself. This he did in his capacity as the plaintiff's physician, and not in his capacity as manager of the hospital. The liability of the defendant hospital must be tested by the same principles that would govern the liability of any other hospital in which the defendant physician had no interest. If he had taken the plaintiff to any other hospital, and taken the matter of wrapping the bottles into his own hands, it is difficult to see on what principle such hospital would be liable for injury resulting from the negligent wrapping of the bottle. The court discovers no principle on which the judgment against the defendant hospital can be sustained.

Appendectomy—Sponge Passed by Bowel—Malpractice

(Mayberry v. Myers et al. (Okla.), 229 Pac. R. 563)

The Supreme Court of Oklahoma, in affirming a judgment for $3,000 in favor of plaintiff Myers, says that the defendant operated on her, removing the appendix, about three fourths of the right ovary, and one fallopian tube. For more than a year she continued to suffer, and lost weight. Then, according to her testimony, one day, when her bowels had not moved for three or four days, she went into the toilet, found something protruding from her, took hold of it, and after two or three efforts pulled out a cloth, which was afterward said to be a surgical gauze sponge. She called her sister, who took the cloth pointed out to her, and told her father of the occurrence. A physician was called, who "found the patient excited," but "didn't see any material difference in the girl," who was about 20 years of age. The physician could not understand how the sponge could have passed through the bowels without leaving an opening that would cause immediate death. He advised going back to the hospital the next day, but the plaintiff insisted on going at once. There roentgenograms were taken, but they failed to show any rupture or other trouble with the bowels.

It was contended that the case rested on the uncorroborated testimony of the plaintiff that the sponge passed from her bowels, but with this the court cannot agree. There was the testimony of her sister, who was called immediately after the occurrence, who said that the cloth was moist and had a strong odor, and the testimony of her mother, who testified that it smelled like the passage from the bowels of a person sick of a fever, and the testimony of the physician summoned that it was moist and "apparently had the matter expelled from the bowels on it." The court thinks that from this evidence the jury was justified in finding that the sponge offered in evidence passed through the bowels of the plaintiff.

Another contention was that on the testimony of expert witnesses it was impossible for the sponge to have passed through the wall of the ascending colon and to have passed

through the colon. But one significant fact that no doubt impressed the jury was that the plaintiff began to improve immediately after passing the sponge, and at the time of the trial was apparently in good health. The court thinks it very probable, too, that the jury did not rely on the testimony of the defendant as being wholly accurate when he testified that no sponges were used in performing the operation. The court thinks that the case was properly submitted to the jury, and it is unable to say that the jury reached an incorrect conclusion.

It was contended that the rule laid down in *Cassingham* v. *Berry*, 67 Okla. 134, 150 Pac. 139, 168 Pac. 1020, should be applied. In that case it was held that an instruction to the effect that, although the jury might believe from the evidence that a sponge was inadvertently left in the abdominal cavity, still if it believed that the surgeon, in performing the operation, exercised ordinary care in keeping track of the sponges and in seeing that they were all removed before the incision was closed, its verdict should be for the defendant, was a correct statement of the law, and properly given. To that contention the court thinks it sufficient to say that the instruction approved in the Cassingham Case was given in this case, and no complaint was made of the instructions.

Again, it was suggested that this court had created an exception to the general rule that in law actions the judgment will be affirmed when there is any evidence reasonably tending to support the verdict. The reason for that exception has been stated to be that a physician is obliged by his calling to enter the abode of others and frequently to undertake difficult cases and to perform critical operations in the presence of those who are ignorant and credulous, and is liable to have his acts misjudged and the truth colored or distorted. But while this court heartily approves of the further statement that it is the intention of the law to protect the physician or surgeon as well as the patient, it may with equal soundness be said that it is the intention of the law to protect the patient as well as the surgeon. The conditions pointed out for making certain cases an apparent exception to the general rule were wholly different from the circumstances of this case. Here the operation was performed in the defendant's own hospital, where he was surrounded by associate physicians and his own employees. There was no occasion here for such exception.

Malpractice—Punitive Damages—Wealth of Physician

(Smith et al. v. Corrigan, N. J.), 126 Atl. R. 680)

The Supreme Court of New Jersey says the testimony showed that Mrs. Smith bruised one of her legs and that a lump appeared on the shin bone at the point of injury. About three weeks and a half after the accident, in which period she had had treatment at a hospital and at home, Mrs. Smith called in the defendant. He pronounced the injury a hematoma, and advised that it be opened. He had no instruments with him, and asked for a safety razor blade. One was furnished, an incision was made, and the wound dressed. The defendant had nothing further to do with the case. The wound became infected. Another operation was performed, and, after a slow healing, the leg was left scarred and shriveled. The defendant contended that the infection had already set in when he was called, and that he took every precaution to insure asepsis by washing his hands, cleaning his nails, boiling the razor blade, and using an antiseptic solution; but Mrs. Smith and a friend who was with her at the time denied that the defendant used these precautions. The case was, the court thinks, properly submitted to the jury, which returned a verdict of $500 in favor of Mrs. Smith and of $2,000 in favor of Mr. Smith. But there were certain vitiating errors in the trial.

During the trial the defendant was asked what he considered his fair net worth in money was. Over objection, the defendant testified that he was worth over $100,000. The complaint demanded punitive damages, and the trial court proceeded on the theory that if punitive damages were demanded in the complaint, evidence of the pecuniary wealth of the defendant was proper. Where malice or a wrongful motive exists, punitive damages may be recovered. But outside of certain exceptional cases wherein wealth is necessarily involved in determining the damages sustained, evidence of wealth is inadmissible unless there be proof of malice. The question at issue was whether the defendant had exercised the skill and care ordinarily possessed and exercised by others in his calling, not the wealth or the poverty of the defendant. The court can see in the testimony no basis for punitive damages. There was nothing which suggested malice on the part of the defendant. It seems unusual to use a safety razor blade to open a blood tumor, but from this circumstance alone a wrongful motive on the part of the defendant toward Mrs. Smith could not be inferred. In the absence of a foundation on which to rest a claim for punitive damages, it was improper to force the defendant to testify to his wealth. The testimony was irrelevant. While the verdicts were not large, yet it could not be said that the evidence might not have tended to cause in the minds of the jury a sympathy for Mrs. Smith and a justification for the separation from the defendant of some of his abundant means to compensate Mrs. Smith for her warped and withered limb, unwarranted by the evidence.

The same error appeared again in the charge to the jury that unless it found that there was a wrongful intent on the part of the defendant to injure Mrs. Smith, and that this culminated in a wrongful act, done intentionally, and without just cause or excuse, it could find no punitive damages. The charge assumed that there was evidence from which a wrongful intent on the part of the defendant could be found. But this court thinks there was no evidence. It was therefore error to have charged the jury in the manner stated.

It was also error to charge the jury that a physician responding to a call impliedly engages to employ the degree of skill and knowledge ordinarily exercised in his profession by physicians of good standing practicing in the locality and similar localities. The skill and care a physician is required to give a patient is that ordinarily possessed and exercised by others in the profession.

Award for Enucleation of Blind Eye

(London Guarantee & Accident Co., Limited, et al. v. Industrial Commission of Colorado et al. (Colo.), 230 Pac. R. 598)

The Supreme Court of Colorado says that an employee, by an accident arising out of and in the course of his employment, suffered an enucleation of the eyeball of a blind eye. The workmen's compensation act of Colorado provides for compensation for "the loss of an eye by enucleation (including disfigurement resulting therefrom), 139 weeks. Total blindness of one eye, 104 weeks." The commission may allow not exceeding $500 for facial disfigurement. In this case the commission awarded the employee compensation for 139 weeks, and the district court affirmed the award. But the supreme court holds that this was not right, as it made the statute give more for the loss of a blind eye than for the loss of the sight of a good one. This court deems it clear both from the statutory contexts mentioned and from the natural reason of the matter that the intent and spirit of the statute is, in case of enucleation, to compensate for the loss of both sight and disfigurement, and it should be so construed, notwithstanding that its letter justifies the construction given by the industrial commission and the district court. Wherefore the judgment of that court is reversed, with directions to set aside the award of 139 weeks for enucleation, and to order the commission to make an award for disfigurement, if it deems it proper to do so.

Sale of Drugs as the Practice of Medicine

(People v. Poo On (Calif.), 230 Pac. R. 193)

The District Court of Appeal of California, Third District, in affirming a judgment of conviction of practicing medicine without a license, says that the only ground urged for a reversal was that the evidence did not show that the defendant was engaged in the practice of medicine, but only that he was engaged in the sale of herbs. The character of the proof presented was indicated by excerpts from the testimony of the first witness. The witness testified that she visited the defendant in regard to medical treatment, though she

didn't know that the way he treated would be called medical; that she went for the purpose of getting his herbs, but did not know what kind of herbs she got; that she got the herbs he gave her through her stating her case to him; that she stated her case, and he answered the questions back; that is, he told her what he thought. To the question of whether, after she had stated her case, the defendant asked with reference to any particular symptoms of trouble or disease, the witness answered, "Yes." After that, the witness said, she thought he named in a way what he thought was ailing her; that he said he thought it was gastric trouble. The witness testified further that when she went to the defendant she did not ask him for a particular brand of herbs, or medicine; that he determined what kind of medicine she should take; that she did not know what she was to take until she got it; that on the first visit she paid the defendant $15; on the second, $6; and on the third, $8. Other witnesses gave similar testimony. Counsel for the defendant did not point out wherein the defendant's practice differed, in legal effect, from that of duly licensed physicians, and this court is unable to discover any difference.

Society Proceedings

COMING MEETINGS

Conference of State and Provincial Health Authorities, Montreal, Canada, June 4-5. Dr. Richard M. Olin, State Commissioner of Health, Lansing, Mich., Secretary.

Maine Medical Association, Bar Harbor, June 23-25. Dr. B. L. Bryant, 265 Hammond Street, Bangor, Secretary.

Massachusetts Medical Society, Boston, June 9-10. Dr. W. L. Burrage, 182 Walnut Street, Brookline, Secretary.

Montana, Medical Association of, Lewistown, July 8-9. Dr. E. G. Balsam, 222 Hart-Albin Building, Billings, Secretary.

New Jersey, Medical Society of, Atlantic City, June 18-20. Dr. J. B. Morrison, 97 Halsey Street, Newark, Secretary.

North Pacific Pediatric Association, Portland, June 29. Dr. E. J. Barnet, Paulsen Building, Spokane, Wash., Secretary.

Pacific Northwest Medical Association, Portland, Ore., June 29-July 1. Dr. Frederick Epplen, Paulsen Building, Spokane, Wash., Secretary.

Rhode Island Medical Society, Providence, June 4. Dr. J. W. Leech, 369 Broad Street, Providence, Secretary.

West Virginia State Medical Association, Bluefield, June 9-11. Mr. Sterritt O. Neale, 211 Smallridge Bldg., Charleston, Executive Sec'y.

ASSOCIATION OF AMERICAN PHYSICIANS

Fortieth Annual Meeting, held in Washington, D. C., May 5-7, 1925

(Continued from p. 1598)

Relation of Morphology to Prognosis of Aortic Syphilis

DR. W. W. G. MACLACHLAN, Pittsburgh: Last year Dr. Scott reported twenty-five cases of syphilitic aortic insufficiency. The point he brought out is that symptomatically the cases illustrated cardiac failure due to aortic regurgitation. Necropsy showed aortitis, extending into the aortic orifice, producing aortic valve lesions. The coronaries were involved in a certain number of cases. The average duration of life was nine months after the beginning of symptoms; there was no response to treatment. I agree with Dr. Scott that there is a very definite group of aortic syphilis, particularly in hospital practice, and in my experience particularly among negroes. Some of this group live much longer than the average. I have not been impressed with antisyphilitic treatment. There is another group of aortic syphilis which shows some difference in morphology, in that the aortic cusps are not involved; there are also differences in symptoms, in that they are referable to the aorta and not to the heart. These patients live longer, and they react more favorably to treatment. In my opinion the morphologic character of the distribution of the syphilis in the aorta is responsible for this group. In the earliest lesions of syphilis the lesions begin about 1½ or 2 inches above the aortic cusps, and spread over the thoracic aorta, rarely going beyond the diaphragm. They do not involve the aortic valve. The interesting thing about the distribution of syphilis lesions in the aorta is that the first 1½ inches is not involved as commonly as the rest. It was suggested by Klotz that the lymphatic distribution is not as great in that portion of the aorta as in the others. The fibrosis present represents healing, even when other areas show progressive lesions. The two points that I wish to bring out regarding the morphology is that syphilis does not necessarily get to the aortic cusp, and that dilatation may occur with perfectly normal cusps; and, secondly, that fibrous tissue tends to occur repeatedly in the aorta. I wish to emphasize the possibility of producing fibrosis in clinical cases. Whether one can kill the spirochete in that stage is very doubtful; but to put the spirochete in the stage in which fibrosis will occur is what we can hope for. I doubt in clinical work that we shall see aortic syphilis very early, because symptoms may not appear for years after the primary lesion. It may be recognized, however, in routine examinations a long time before symptoms appear.

DISCUSSION

DR. ALFRED S. WARTHIN, Ann Arbor, Mich.: As a matter of fact, aortic syphilis, in the great majority of cases, is not associated with disease of the aortic valve, and the part of the aorta most frequently involved is at another point. In many cases the most marked lesions are in the abdominal aorta; in others, in the thoracic aorta, while the most severe forms are in the descending part and so the diffuse forms of syphilitic aortitis are found in the thoracic part of the aorta. The large branches of the aorta show marked lesions, so that one must bear in mind the capricious localization of syphilitic lesions, and that aortic syphilis is not syphilis of the aortic valve in the great majority of cases. It is only a rare event.

DR. HOWARD T. KARSNER, Cleveland: I am in entire agreement with Dr. Warthin as to the infrequency of valve lesions in association with syphilitic mesaortitis. As a matter of fact, it required more than three years for Dr. Scott to collect the cases that he reported in his paper, in spite of the fact that in the City Hospital, Cleveland, there are about 500 necropsies annually. This establishes the infrequency of the lesion under consideration. It is gratifying to have Dr. Maclachlan's confirmation of the general results, but it seems to me that the emphasis should be placed on the poor prognosis in cases of syphilitic mesaortitis with definite valve defects present, rather than on the generally more favorable outlook in cases in which such defects are absent. I agree with Dr. Warthin that it is unwise to be dogmatic in such matters, but, with one exception, Dr. Scott was able with great assurance to prophesy a short duration of life. The average of nine months is like all averages; a few cases of long duration bring the average considerably above the duration in the majority of instances. Finally, I wish to bring up the matter of healed aneurysms. The fibrosis of the wall of an aneurysm is to be regarded as a cicatrix. If such cicatrization limits the dilatation of the vessel, scarring in this situation must be of a different nature than in other situations, because it is well known that under pressure a scar has a tendency to expand. From our point of view, the presence of such cicatricial fibrous tissue in the wall of aneurysms disposes to continuous dilatation as long as there is intravascular hydrostatic pressure.

DR. W. G. MACCALLUM, Baltimore: The statements about the relation of valve lesions to aortic syphilis should be more exact. It seems to me that there must be more than 20 per cent. of aortic insufficiency in cases that are recorded as cases of aortic syphilis. The widespread induration of the adventitia, which is apparently a protective alteration, should be more generally emphasized in cases of aortic syphilis than is usual.

DR. LEWIS A. CONNER, New York: I do not feel that the clinicians are perhaps quite so "hidebound" in the matter of featuring the point of aortic insufficiency. The trouble is that the presence of aortic insufficiency is essential, or almost essential, to the clinical diagnosis of aortic syphilis. I myself at least am unable usually to make the diagnosis without it. I am unable to differentiate in most cases, in the absence of aortic insufficiency, between the changes in the aorta in essential hypertension and those in syphilis. Changes in the fluoroscopic shadow are found so commonly in persons of middle age, whether they be syphilitic or not, that it may be

a very difficult matter to establish the diagnosis of aortic syphilis unless there is aortic insufficiency. We all recognize the fact that those patients with aneurysm or without aortic insufficiency have usually a much longer lease of life. The other point I should like to make is that it is not the development of the aortic leak itself that makes the difference in prognosis; that is relatively unimportant. The thing that makes the difference in prognosis is that when the aortic cusps are involved there has been an extension of the process to those cusps, and in that extension there has been an encroachment on the orifices of the coronary arteries, or else an associated involvement of the heart muscle in that process, and the syphilitic myocarditis or the encroachment on the mouths of the coronary arteries are the things that determine the very bad prognosis in cases in which there is aortic insufficiency.

DR. R. T. BOGGS, Baltimore: I should like to emphasize what Dr. Conner said, from the standpoint of teaching, as to the extremely "muddy" ideas that the young staff members in the hospitals have regarding the diagnosis of syphilitic aortitis. The freedom with which the term is used as a "clinical entity" far exceeds the clinical justification.

DR. CHARLES F. HOOVER, Cleveland: The method of examination varies among clinicians, and I believe the methods of examination will determine the clinician's interpretation, not only the diagnostic interpretation, but the subsequent course of the disease. If one relies on the roentgen ray to detect the early modification of the elongation and dilatation of the aorta, and many men leave it for the roentgen ray to show them the first sign of involvement of the aorta, they will miss all the best cases, for one can detect the changes in the aorta before the roentgen ray will show them. If one will use his ear by direct application to the chest, instead of using the stethoscope, one may detect many cases of early aortitis which, with the stethoscope and by relying on the roentgen ray, he will miss.

Effect of Sleep on Normal and High Blood Pressure

DR. M. A. BLANKENHORN, Cleveland: It is generally conceded that isolated and single observations on blood pressure may lead to erroneous conclusions; and it is true that many allowances must be made for physical, psychic and metabolic activity. These variables come to a more or less constant level during sleep, which constitutes from a fourth to a third of our entire living, but the study of blood pressure during sleep has been almost negligible. From the work that has been done it is not apparent that taking the blood pressure interferes with sleep, nor is it true that what disturbance may be produced in waking causes fluctuations in the blood pressure. Leonard Hill came to the conclusion that there is little or no drop in blood pressure during sleep. Brush and Fairweather demonstrated that there is a distinct drop in blood pressure during sleep, and stated that the maximum drop occurred within the first two hours, following which there was a gradual rise, so that the blood pressure came back almost to normal at the end of sleep. Brooks and Carroll came to the same conclusions as to normal blood pressure, and recorded findings on patients with high blood pressure; here the drop was proportional to the elevation; the greater the elevation, the greater the drop. The apparatus used by me for the determination of blood pressure during sleep is a manometer and combined oscillometer. By this device we studied twenty-five normal young adults about to be discharged from the hospital for minor ailments. They were kept in bed during the day for a twenty-four hour cycle for the period of the experiment, and all activity was reduced to a minimum. We found that so small a change may occur in sleep that we must take into consideration the posture of the patient. The nurse makes the observation whether the patient lies on his back, on the right or on the left side, the cuff being on the left side. We found the maximum drop in the first two hours, followed by a gradual drop and then a rise. Thirty-three patients with high blood pressure were then studied. The first group consisted of those who showed a drop during sleep which might be considered normal. Then there was a group which maintained the high blood pressure during sleep. In general, perhaps this method may be used in determining those patients who may be benefited by bringing about a drop in blood pressure, and those patients who had more evidence of arteriosclerosis and are incapable of having any particular fall in blood pressure. In one group there may be, perhaps, harm in attempting to lower the blood pressure; in the other, benefit may accrue by a lowering of the pressure.

DISCUSSION

DR. E. B. KRUMBHAAR, Philadelphia: An interesting light is thrown on this question by some recent work of McWilliam of Aberdeen, who found a rise in blood pressure during sleep which amounted to sometimes as much as 20 or 30 mm. of mercury. He found this to be especially frequent during disturbed dreams, or when there was some sudden disorder of the cardiac mechanism, such as heart block. I was interested in it because of its relation to some studies on spontaneous rupture of the heart that we have recently been making. We found that twenty-one hearts ruptured during sleep, which was the highest single group in our series of 600-odd cases. (Most of these were taken from the literature.) This seems to lend some weight to the idea that an increase in blood pressure may occur during sleep, and may even be of clinical significance. I would be interested to know whether Dr. Blankenhorn noticed any notable rise in blood pressure in his cases.

DR. M. A. BLANKENHORN, Cleveland: In some of the records, especially those with abnormally high blood pressure, we did see a very marked rise during sleep, and sometimes a continued rise for several hours, and then a fall, so that it is impossible to put them together as a group simply on the basis of the heart activity or the nature of the vessels.

Possible Relationship Between Guanidin and High Blood Pressure

DR. RALPH H. MAJOR, Kansas City, Mo.: The possible relationship of certain products of metabolism to arterial hypertension has been expressed in medical literature from time to time. Some observers have suggested that such a hypothetic substance was produced in excess, while others have suggested the retention of such substances. A systematic study of the known metabolites of the urine in regard to their pressor effect yielded results so striking as to suggest a possible etiologic relationship. The pressor effects of the guanidin base are truly remarkable. The injection of guanidin in dogs is followed by a gradual increase in the blood pressure, persisting often from four to five hours without reinjection. In a decerebrated dog we could produce a marked rise in blood pressure by the intravenous injection of methylguanidin sulphate. In rabbits there was such a marked vasoconstriction of the vessels that it was impossible to get blood from the animal's ears, and we were forced to recover the blood by cutting the jugular or going directly into the heart. Another interesting observation along this line is that the direct inspection of the retina of the dog following injection of guanidin bases shows a constriction of the small arterioles of the retina. These observations suggest a peripheral action of this substance which is in harmony with much of the best thought in regard to the production of arterial hypertension. Patients with arterial hypertension usually had a lower excretion of these bases than normal persons or those suffering from other diseases. In cases of essential hypertension and chronic nephritis we have not encountered any constant increase in blood guanidins. This led us to the study of the guanidin content of the blood in animals that had received injections of guanidin bases. There was at first a rise in guanidin, but within five minutes a fall to normal, in spite of the fact that hypertension persisted from four to five hours in many of the experiments. Such findings suggest certain possibilities: rapid excretion of guanidins; storage in some tissue; transformation into some other substance that has a prolonged pressor effect, or rapid saturation with destruction of the excess. The urine, after injection of guanidin compounds, shows, however, no constant increase in guanidin bases, and removal of both kidneys, excluding the possibility of urinary secretion, does not prevent the

rapid disappearance of guanidin from the circulation. The guanidin content of the muscles, lungs, liver, heart, brain, spleen and kidneys after injection with guanidin bases is apparently no greater than that of normal controls. When we consider the possibility of guanidin being changed into some other pressor substance, a study of its chemistry would indicate that it is probably either transformed directly into urea or first into cyanamid and then into urea. We have studied the action of both urea and cyanamid, and neither has any pressor effect. We have also studied the effects of certain substances on hypertension produced by guanidin. Calcium chlorid and a mixture of calcium and potassium chlorid produce a very prompt fall in hypertension produced by guanidin. The same thing is true of parathyroid extract and also of some other tissue extracts, notably that obtained from liver. It is of interest that the elevation in blood pressure produced by guanidin compounds is accompanied by a fall in calcium, whereas the fall in blood pressure produced by parathyroid extract is accompanied by a rise in calcium. The evidence that guanidin is concerned in arterial hypertension is sufficiently suggestive to warrant further examination.

Classification of Bright's Disease in Terms of Nature of Renal Lesion

DR. THOMAS ADDIS, San Francisco: The examination of a consecutive series of urine specimens from a patient with Bright's disease may show in one specimen many casts and red blood cells; in another, few or none. I made a study of the physical factors that influence the formed elements of the urine. Hyaline casts and all casts whose matrix is hyaline dissolve in solutions of sodium chlorid when the concentration is reduced. Some years ago I began a differential cast count, and since then I have added counts on the red blood cells, the white blood cells, and small epithelial cells. Each addition to the sum of the quantitative data has strengthened the growing sense that we may attain by some means a knowledge of the actual process active in the kidney, and follow the development of the lesion in the kidney from the beginning to the end. The results presented here are averages from 140 patients whose urine contained albumin and casts. These sediments on quantitative as well as qualitative grounds fell into three main classes. On clinical grounds I have become convinced that these classes represent three diseases pathologically and etiologically distinct and separate. The first is the glomerular nephritis of the pathologist, but I think the term hemorrhagic Bright's disease is better, because it calls attention to the constant presence of large numbers of red blood cells in the urine. The initial stage of this condition is a streptococcal infection. In the more severe forms the urine contains red blood cells, and there are a number of casts, varying in color from lemon yellow to dark brown. Red blood cells can be seen deposited on the matrix of the casts. With the subsidence of the streptococcus infection, there is healing. There may be a latent stage, which is probably due to a continuance of the focal streptococcus infection. In this stage patients go on for years, always with a number of red blood cells and a few blood clots in the urine. As time goes on there is usually a fatty degeneration of the tubules and an appearance in the urine of fatty casts and fat droplets. The lesion eventually passes, if the streptococcus infection continues, into the terminal stage. In the terminal stage, there is a gradual but very radical alteration in the nature of the urinary sediment. Fewer red blood cells and pus cells appear, and blood clots are difficult to find. When the amount of secreting tissue is decreased to less than a third of the original amount, the urea concentration of the blood rises. The second disease has been called degenerative Bright's disease, because the most prominent feature of the sediment is the large number of epithelial cells in various stages of granular and fatty degeneration. Degenerative Bright's disease is not a unity, but only a convenient term to describe those cases which give rise to degenerative changes in the kidney. The etiology of degenerative Bright's disease may be classified as follows: (1) cryptic (in which the cause is unknown); (2) poisons, of known chemical nature, e. g., pregnancy toxemia; toxemia of generalized infection; toxemia of focal infection; toxemia in mixed infections; (3) arteriosclerotic. By following the formed elements of the urine in the same patient from day to day there may be constructed a clear picture, illustrating the rise and fall and the ultimate diminished activity in renal lesions. The classification is an attempt to advance the establishment of a purely etiologic classification, which must always remain the goal toward which we strive.

DISCUSSION

DR. HENRY A. CHRISTIAN, Boston: The classification suggested being simple, is probably workable, and being workable in the clinic, it will probably lead to a larger knowledge of the disease. Working at the question from a somewhat different point of view, I, too, have arrived at a simple classification. I do not think the terminology used makes any difference. The importance is the simplicity. Another point I should like to emphasize is that the last group, the unknown group, as far as the etiology is concerned, is the important group, because that makes up an extremely large percentage of the cases that we regard as cases of chronic Bright's disease. In our own studies, out of 1,650 cases studied with considerable care, 1,600 belonged to this last group, and the other fifty might be grouped with the hemorrhagic or degenerative types. Finally, I should like to emphasize that most cases of chronic nephritis, i. e., those in the last group, are really forms of vascular disease, rather than, strictly speaking, renal disease, and we shall make more progress in their study if we pay less attention to the kidney and more attention to the general circulation.

Blood Volume in Relation to Diet and Experimental Kidney Lesions

DRS. T. F. ALLEN, R. SCHARF, and H. LUNDIN, Morristown, N. J.: As fairly satisfactory reproductions of clinical kidney disease were obtained in partially nephrectomized animals, it was thought of interest to see how these animals react in relation to blood volume. Congo red was injected because this dye clears up readily from the blood; it is completely gone in three or four hours. The dye was injected in 1 per cent. solution, from 3 to 5 mg. per kilogram of body weight. The experiments were performed on dogs, sheep and goats. In the first experiments we gave to normal animals and to the experimental animals more water than the normal kidney can excrete, 75 c.c. per kilogram of body weight, whereas from 30 to 40 c.c. is the amount the normal dog can excrete in four hours. If normal animals are given such a surplus of water, it is well known that no change occurs in the blood volume. It is simply retained in the tissues. The blood is kept fairly constant by the regulatory mechanism. In the animals with injured kidneys, eighty minutes after the administration of water there is an increase in the plasma volume of 28 per cent. We thus have true hydremia in these animals with the damaged kidney. The experiments showed that most of the water was stored outside the blood, even in these animals. A normal dog given 9 gm. of salt and 350 c.c. of water by mouth showed an increase in the plasma amounting to only 7 per cent. Another with only one kidney (normal) received 10 gm. of salt and 500 c.c. of water, and there was an increase of 9 per cent. of plasma volume. A dog with one damaged kidney receiving the same amount showed an increase of plasma volume of 32 per cent. A dog with half a normal kidney received the same dose, and there was an increase of 18 per cent. of plasma volume. Sheep showed the same results. Herbivorous animals are useful because they can stand so much salt or water without diarrhea or disturbance. In a goat having only one fifth of one kidney remaining, salt feeding resulted, on the whole, in a diminution of blood volume; instead of the increase seen in normal animals, there was a slight decrease of volume. The main point is that heretofore it has been necessary in kidney work to assume damage to the blood vessels in addition to the damage to the kidneys to account for the phenomena of edema. If this work is valid, we can refer kidney disease back to the kidneys. They appear to exercise a regulatory effect on the relations between the blood and the tissues.

(To be continued)

Current Medical Literature

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Titles marked with an asterisk (*) are abstracted below.

American Journal of Electrotherapeutics and Radiology, New York

63: 54-80 (Feb.) 1925

Report of Committee on High Frequency Currents. F. de Kraft.—p. 45.
Diathermy in Lobar Pneumonia. H. E. Stewart, New Haven and Waterbury, Conn.—p. 49.
Physiotherapy of Some Peripheral Circulatory Diseases. C. S. Thomson, Newark, N. J.—p. 57.
Report of Committee on Standardization of Therapeutic Apparatus. N. C. Titus.—p. 60.
Gonorrheal Ophthalmia Treated by Radiant Light and Heat. C. A. Palmer, Red Bank, N. J.—p. 62.

American Journal of Hygiene, Baltimore

5: 127-244 (March) 1925

Reaction Product Which Inhibits Reproduction of Trypanosomes in Infections. F. A. Coventry, Baltimore.—p. 127.
Activation of Yeast Absorbed Complement with Heated Serums. R. R. Hyde, Baltimore.—p. 145.
Identification of Larvae of Three Common Anopheline Mosquitoes of Southern United States. P. F. Russel.—p. 149.
Effect of Fatigue on Susceptibility of Rabbits to Intratracheal Injections of Type I Pneumococcus. G. H. Bailey, Boston.—p. 175.
*Plague Transmission Through Ectoparasites of Tarabagan. W. L. Teh, J. W. H. Chun and R. Pollitzer, Harbin, China.—p. 196.
Utilization of Solar Light and Heat in Treatment of Night Soil. M. E. Barnes.—p. 202.
Specificity of Hemolytic Antibodies. R. R. Hyde, Baltimore.—p. 217.
Immunization with Heterophile Antigen When Given by Mouth. H. M. Powell, Baltimore.—p. 228.

Plague Transmission by Tarabagan Fleas.—Teh, Chun and Pollitzer have succeeded in infecting a healthy animal by means of tarabagan fleas, which they are convinced were involved not only in the constant Siberian outbreaks, but also in others when a direct contact with infected animals occurred. The lice are certainly an important link in the propagation of the disease from animal to animal, but it is at present difficult to gage how far the lice have actually spread the disease to man. A few outbreaks, where the affected had contact with tarabagan skins only, seem somewhat suggestive of their rôle. These observations, made both on the fleas and on the lice, show that any attempt to control the handling of tarabagans and the trade with their skins must include not only bactericidal, but also insecticidal measures.

American Journal of Roentgenology and Radium Therapy, New York

13: 203-306 (March) 1925

Intrathoracic Changes Induced by Heavy Radiation. W. A. Evans and T. Leucutia, Detroit.—p. 203.
Abdominal Deep Therapy Injuries. C. F. Ball, Rutland, Vt.—p. 220.
Thymus Stimulation by Roentgen Rays. M. Lenz, New York City.—p. 226.
Treatment of Malignancies by Radiation. S. Withers, Denver.—p. 235.
Treatment of Malignant Neoplasms by Fractional Roentgen Ray Radiation Technic. J. D. Morgan, Philadelphia.—p. 244.
Cancer of Esophagus Treated with Radium. R. W. Mills and J. H. Kimbrough, St. Louis.—p. 247.
Diagnostic Pneumothorax. H. J. Isaacs, Chicago.—p. 250.
Reminiscences of Pioneer in Roentgenology and Radium Therapy. F. H. Williams, Boston.—p. 253.
Tetrabromphenolphthalein Sodium Salt in Roentgenographic Diagnosis of Gallbladder Disease. W. H. Stewart, New York City.—p. 259.
Nontraumatic Diaphragmatic Hernia: Fifty-three Cases. T. R. Healy, Boston.—p. 266.
*Congenital Anomaly of Patella: Case Report. A. W. George and R. D. Leonard, Boston.—p. 271.

Congenital Anomaly of Patella.—George and Leonard have seen six cases in which the outer and upper quadrant of the patella consisted of a separated piece of bone. Five of the six cases were bilateral.

Archives of Dermatology and Syphilology, Chicago

2: 425-578 (April) 1925

*Interpretation of Mycosis Fungoides as Variety of Lymphosarcoma. J. F. Fraser, New York.—p. 425.
*Ringworm of Scalp in Adults. H. Fox and R. W. Fowlkes, Richmond, Va.—p. 446.
*Leiomyoma Cutis. O. S. Ormsby, Chicago.—p. 466.
*Sarcomatosis Cutis of Spiegler. Sarcoid of Spiegler-Fendt. S. E. Sweitzer, Minneapolis.—p. 481.
Studies on Hair; Hypertrichosis. C. H. Danforth, St. Louis.—p. 494.
*Mercurosal in Experimental Rabbit Syphilis. O. M. Gruhzit, Detroit.—p. 509.

Mycosis Fungoides Variety of Lymphosarcoma.—Fraser reports three cases of mycosis fungoides which were undoubtedly cases of lymphosarcoma arising in the perivascular reticular system of the skin.

Ringworm of Scalp.—Three cases are reported by Fox and Fowlkes of ringworm of the scalp occurring in adult negroes, aged 45, 26 and 36 years, respectively. The lesions in two cases consisted of bald patches with broken hairs and slight scaling. The third was a kerion. Microscopic examination was positive in hairs from two cases and scales from a third (kerion). Cultures on Sabouraud's isolation medium showed *Microsporon lanosum* in a second. The time was too short to learn results of cultures in the third case. Culture of *Microsporon lanosum* was successfully inoculated into a guinea-pig and a pure culture later recovered. Fermentation tests on mannite and lactose-saccharose were made in two cases, which showed that *Microsporon lanosum* grew and fermented these sugars more rapidly than *Microsporon audouine*, thus agreeing with the findings of Hopkins and Iwamoto.

Leiomyoma Cutis.—The first of the two cases recorded by Ormsby was considered to be a syringocystadenoma until the myomatous nature was demonstrated microscopically. The second case, in which pain was present, seen a few months later, was immediately recognized clinically. From the histologic study made, the arrectores pilorum were the points of origin, and the character of the new growth supports the theory that pain is induced by pressure of the compact new growth on nerve fibers.

Sarcoma Cutis of Spiegler.—The points of interest in the case reported by Sweitzer are: First, a man of advanced years had nodules under the skin. These were sectioned and found to be sarcomatous. Without any therapy, the tumors regressed. He was observed then over a period of nearly a year, when the tumors reappeared, and he declined rapidly, dying of inanition. The necropsy findings did not reveal a great enough pathologic condition to account for his death. None of the essential organs was involved sufficiently to interfere greatly with function. The case in all its details corresponded to the clinical syndrome called sarcomatosis cutis of Spiegler.

Mercurosal in Experimental Syphilis.—Having investigated the germicidal power of mercurosal in vitro on *Spirochaeta novyi* and *S. pallida*, Gruhzit found that it is slight as compared with that of inorganic mercurials. Repeated administrations of mercurosal at two to three day intervals in doses of from 3 to 5 mg. produced no noticeable toxic symptoms in rabbits.

Archives of Otolaryngology, Chicago

1: 367-471 (April) 1925

Morphologic Variation as Factor in Symptomatology of Paranasal Sinus Disease. H. Neivert, New York.—p. 367.
*Unusual Pharyngeal Lesions. G. B. New, Rochester, Minn.—p. 384.
Pneumoventriculography in Localization of Brain Abscess. E. R. Carpenter, Dallas, Texas.—p. 392.
Treatment of Deafness by "Acoustic Method." S. Salinger, Chicago.—p. 397.
*Tuberculosis of Upper Respiratory Tract. J. W. Babcock, New York.—p. 406.
Masked Mastoiditis Simulating "Alimentary Intoxication" (Anhydremia). M. L. Floyd, Iowa City.—p. 411.
Exophthalmos as Complication of Nasal Sinusitis. C. F. Yerger, Chicago.—p. 415.

Unusual Pharyngeal Lesions.—The four cases reported by New are illustative of diseases which may manifest themselves first in the nose, throat or mouth. The lesions were

all different and unusual. They were: (1) a case of nodular tumors of the mucous membrane of the pharynx and larynx in chronic lymphatic leukemia; (2) ulceration of the pharynx and mouth in acute lymphatic leukemia; (3) pharyngeal and laryngeal leprosy, and (4) pemphigus of the pharynx and mouth.

Tuberculosis of Larynx.—Babcock emphasizes the fact that by far the most common and important tuberculous lesion of the upper respiratory tract is in the larynx. No tuberculous patient should fail to have his larynx watched, and no persistent laryngitis should fail to impress the physician with the importance of a careful examination of the patient's lungs.

Atlantic Medical Journal, Harrisburg, Pa.

28: 333-416 (March) 1925

*Typhoid Fever. T. B. Futcher, Baltimore.—p. 333.
*Treatment of Typhoid Fever. L. Litchfield, Pittsburgh.—p. 339.
*Public Health Measures in Control of Typhoid Fever. C. H. Miner and H. E. Moses, Harrisburg, Pa.—p. 343.
Treatment of Chronic Suppurative Osteomyelitis. J. H. Jopson and N. S. Rothschild, Philadelphia.—p. 353.
Practical Application of Protein Therapy in Ophthalmology. B. W. Key, New York.—p. 358.
Parasitic Infections of Lung. G. A. Clark, Scranton, Pa.—p. 364.
Combined Excision of Tarsus in Trachoma. H. H. Turner, Pittsburgh.—p. 369.
Atypical Occurrence of Physical Signs in Case of Lobar Pneumonia. J. H. West, Easton, Pa.—p. 373.
Surgical Aspect of Goiter. C. H. Frazier, Philadelphia.—p. 376.
A Few of My Own Personal Mistakes. E. Hess, Erie, Pa.—p. 381.
Specific Cures for Pulmonary Tuberculosis. C. H. Marcy.—p. 385.

Mortality of Typhoid.—The case mortality rate of typhoid fever generally accepted at present, Futcher says, is about 10 per cent. The mortality rate varies greatly in different epidemics, some being much milder than others. The mortality in Osler's wards at the Johns Hopkins Hospital was 9.1 per cent. The death rate from typhoid in New York City for 1917 in 1,442 reported cases was 15.8 per cent. The average annual mortality from 1908 to 1917 in a total of 28,083 cases was 15.18 per cent.

Treatment of Typhoid.—Litchfield says that the average case of typhoid fever requires no medication. When the pulse and heart sounds indicate a failure of the cardiovascular system, digitalis may be given, the method and amount depending on the emergency. Also caffein may be used hypodermically to advantage, in doses from 1 to 6 grains. Nux vomica and strychnin are apparently helpful by their effect on both the digestive tract and the cardiovascular system. For patients that do not take their nourishment well, patients with extreme nervousness, and patients with a weak, rapid pulse, Litchfield believes emphatically in the beneficial effects of alcohol.

Vaccination Against Typhoid. — Vaccination against typhoid, Miner and Moses state, should be constantly urged in communities where typhoid is continuously present, and for those whose occupations require travel or which otherwise expose them to unsafe water supplies or other sources of infection. The value of typhoid vaccination should be explained to students in high schools, colleges and universities, and it should be used as a routine in institutions, hospitals, prisons, reformatories and asylums.

Johns Hopkins Hospital Bulletin, Baltimore

36: 175-224 (March) 1925

Epitheloid Cells of Tuberculous Lesions. M. R. Lewis, H. S. Willis and W. H. Lewis, Baltimore.—p. 175.
*Evidence Showing Existence of Two Distinct Types of Pigment Cells Capable of Giving Rise to Melanotic Tumors. D. T. Smith, Baltimore.—p. 185.
*Recovery of Spirochaeta Pallida from Spinal Fluid of Patient with Syphilitic Meningitis of Neurorecurrence Type. J. E. Kemp and A. M. Chesney, Baltimore.—p. 199.
Hyperplasia of Lipoid Holding Cells in Diabetes with Lipemia. M. C. Smith, Baltimore.—p. 203.
*Fate of Sutures as Observed in Intestinal Anastomosis and in Healing of Wounds. F. L. Reichert and E. Holman, Baltimore.—p. 212.

Two Types of Pigment Cells.—Smith has found two types of cells in the body capable of producing melanin pigment. In tissue cultures the one grows like epithelium, the other like connective tissue. Normally, the epithelial type of pigment cell can be found in the basal layer of the epithelial coat of the skin, hair follicles, retina and certain regions of the brain. The connective tissue type of pigmented cell is found in the choroid of the eye, iris, ciliary body and in the "mongolian spot," when that is present. Observations on pigment cells in the human embryo show that the two types arise independently and in different stages of embryonic development. Among 250 benign moles of the skin, 96 per cent. were of the epithelial and 4 per cent. of the connective tissue type. Among 100 malignant pigmented moles of the skin, 67 per cent. were of the epithelial and 33 per cent. of the connective tissue type. Among thirty tumors of the eye, 20 per cent. were of the epithelial and 80 per cent. of the connective tissue type. Tumors arising in other parts of the body were either epithelial or connective tissue, depending on the type of pigment cell from which they originated.

Spirochaeta Pallida in Spinal Fluid.—Kemp and Chesney relate the case of a man who had the primary sore six months before admission and was treated with two doses of arsphenamin. Three months later acute syphilitic meningitis of the neurorecurrence type developed with paralysis of the left second, seventh and eighth cranial nerves. The spinal fluid was positive. There was no history of secondary manifestations at any time. There was no nausea or vomiting. No symptoms referable to disturbance of the other cranial nerves were noticed by the patient. The spinal fluid examination showed 1,730 cells, 80 per cent. of which were lymphocytes, and a four plus globulin. The Wassermann reaction was completely positive with 0.6 c.c. of fluid in the water bath. At the time of the first puncture, 3 c.c. of the patient's spinal fluid was inoculated into the right testis of a rabbit. Thirty-three days later a small nodule was palpable. Aspiration was not attempted at this time for fear of influencing the course of the lesion. Sixty-eight days after inoculation, the nodule was about 2 mm. in diameter, but aspiration and study by dark field failed to reveal any spirochetes. During the next fourteen days, the nodule increased rapidly in size until it occupied practically the whole of the upper pole of the right testis. Aspiration and study of the material of the nodule at this time, eighty-two days after inoculation, revealed many characteristic, actively motile spirochetes.

Fate of Sutures.—Experiments were made by Reichert and Holman to determine the fate of various sutures in use in intestinal surgery. Absorbable material would seem to be superior when through-and-through sutures are required. Silk sutures employed in intestinal anastomosis migrate either to the peritoneal surface and are covered only by a transparent layer of endothelial cells, or to the lumen of the bowel, into which they eventually drop off and are lost. When the sutures do not enter the mucosa, they migrate toward the peritoneum. If the mucosa is pierced, they slough into the lumen. The presence or absence of infection along the stitch determines in which direction the sutures will travel. Sutures used in the closure of abdominal wounds, when applied so as to constrict the tissues that are included, invariably produce defects in the anterior sheath. Sutures applied so loosely as just to approximate the edges of the wound did not injure the tissues. The vertical figure-of-eight suture is better than the horizontal figure-of-eight suture. Simple vertical sutures are as efficient as the vertical figure-of-eight suture. The results emphasize the importance of gentleness and care in handling tissues.

Journal of Clinical Investigation, Baltimore

1: 317-402 (April 20) 1925

Optical Activity of Glucose as Influenced by Normal and Diabetic Urine. J. R. Paul, Pittsburgh.—p. 317.
*Use of Novasurol in Edema Due to Heart Failure. J. H. Crawford and J. F. McIntosh, New York.—p. 333.
*Diuretic Action of Acid Producing Salts. J. L. Gamble, K. D. Blackfan and B. Hamilton, Boston.—p. 359.
*T Wave of Auricle Appearing in Human Electrocardiogram. H. B. Sprague and P. D. White, Boston.—p. 389.

Treatment of Edema Due to Heart Failure.—The eight cases selected by Crawford and McIntosh for observation were cases of severe heart failure in which edema was a prominent symptom. In six cases, satisfactory diuresis fol-

lowed the injection of novasurol in from 1 to 2 c.c. doses. In one case there was no effect from the administration; this case exhibited an increased urine volume following digitalis administration, and novasurol was given to see whether it could produce an increase in this diuresis. This did not take place. In another case the effect was very slight.

Diuretic Action of Acid Producing Salts.—Gamble, Blackfan and Hamilton found that administration of acid producing salts causes an increased acidity of the body fluids demonstrable in the blood plasma, and an increased excretion of fixed base in the urine, accompanied by a removal of body water which, as indicated by the nearly stationary values for fixed base found in the plasma, is closely proportional to the increase of fixed base excretion in the urine.

Ta Wave of Auricle.—Sprague and White have been able to find a Ta wave occurring after the P wave in electrocardiograms of clinical cases showing complete or high grade partial auriculoventricular block. This wave was found in eighteen out of thirty-seven cases of complete block. The Ta wave is believed to be an accurate expression of the terminal phase of auricular muscle activity.

Journal of Experimental Medicine, Baltimore

61: 439-585 (April 1) 1925

Bimolecular Layers of Lipoids on Chromocytes of Blood. E. Gorter and F. Grendel, Leiden, Holland.—p. 439.
Influence of Low Electromotive Force on Electrophoresis of Lymphocytes of Different Ages. H. A. Abramson, New York.—p. 445.
Relative Reaction Within Living Mammalian Tissues. III. Indicated Differences in Reaction of Blood and Tissues on Vital Staining with Phthaleins. P. Rous, New York.—p. 451.
Resistance of Bacterial Spores to Triphenylmethane Dyes. V. Burke and H. Skinner, Pullman, Wash.—p. 471.
Experimental Syphilis. I. Influence of Size of Inoculum on Course. A. M. Chesney and H. E. Kemp, Baltimore.—p. 479.
Id. II. Influence of Nonspecific Inflammatory Reaction on Development of Chancre. A. M. Chesney and J. E. Kemp, Baltimore.—p. 487.
Urobilin Physiology and Pathology. I. Quantitative Determination. R. Elman and P. D. McMaster, New York.—p. 503.
Id. II. Derivation. P. D. McMaster and R. Elman, New York.—p. 513.
Oxidation-Reduction of Hemoglobin and Methemoglobin. II. By Anaerobic Bacilli and by Sterile Plant Tissue. J. M. Neill, New York.—p. 535.
Id. III. Formation of Methemoglobin During Oxidation of Autoxidizable Substances. J. M. Neill, New York.—p. 561.
Id. IV. Inhibition of "Spontaneous" Methemoglobin Formation. J. M. Neill, New York.—p. 561.
Biology of Bacterium Lepisepticum. I. Effects of Oxygen Tension and Presence of Rabbit Blood on Growth, Dissociation and Virulence. L. T. Webster, New York.—p. 571.

Journal of General Physiology, Baltimore

7: 449-579 (March 20) 1925

Thyroxin as Depressant of Division Rate of Paramecium. H. B. Torrey, M. C. Riddle and J. L. Brodie, Portland, Ore.—p. 449.
Relation of Stability of Protoplasmic Films in Noctiluca to Duration and Intensity of an Applied Electric Potential. E. J. Lund and G. A. Logan, Minneapolis.—p. 461.
Factors Affecting Transmission and Recovery in Passive Iron Nerve Model. R. S. Lillie, Chicago.—p. 473.
Symbiosis Between Chorella Sp. and Azotobacter Chroococcum and Nitrogen Fixation. C. B. Lipman and L. J. H. Teakle, Berkeley, Calif.—p. 509.
Acid Agglutination of Mixtures of Oppositely Charged Bacterial Cells. L. T. Webster, New York.—p. 513.
Growth of Duck Weeds in Mineral Nutrient Solutions With and Without Organic Extracts. A. Saeger, Kansas City, Mo.—p. 517.
Metabolism During Embryonic and Metamorphic Development of Insects. D. E. Fink, Philadelphia.—p. 527.
Neuroid Transmission in Ciliated Epithelium. J. Wyman, Jr., Cambridge, Mass.—p. 545.
Importance of Maintining Certain Differences Between Cell Sap and External Medium. W. J. V. Osterhout, New York.—p. 561.
Temperature Characteristic for Heart Rhythm of Silkworm. W. J. Crozier and H. Federighi, New Brunswick, N. J.—p. 565.
Temperature Characteristic for Pharyngeal Breathing Rhythm of Frog. W. J. Crozier and T. B. Stier, New Brunwick, N. J.—p. 571.

Journal of Infectious Diseases, Chicago

36: 343-421 (April) 1925

Microbic Respiration. IV. So-Called Aerobic Growth of Anaerobes: Potato Respiration. F. G. Novy, Jr., Ann Arbor, Mich.—p. 343.
*Pathogenicity of Clostridium Botulinum. W. A. Starin and G. M. Dack, Chicago.—p. 383.
Staphylococci from Liver, Gallbladder and Intestine of Normal Dogs. L. Arnold, E. R. Balthazar and R. C. Drago, Chicago.—p. 413.
*Culture Mediums for Gonococcus. F. W. Mulsow, Iowa City.—p. 419.

Pathogenicity of Clostridium Botulinum.—Collodion sacs were employed successfully by Starin and Dack in the study of pathogenicity of *Clostridium botulinum* and furnished definite evidence of the multiplication and toxin production of the organism in the body of animals.

Gonococcus Culture Mediums.—Mulsow found that the addition of levulose or maltose and the indicator bromcresol purple to ascitic fluid agar gives a medium on which the gonococcus grows readily and can be distinguished easily from other associated organisms. By the use of the mediums described, discharges in cases of chronic gonorrhea that were considered free from gonococci on the examination of smears, were found to contain gonococci in cultures.

Journal of Laboratory and Clinical Medicine, St. Louis

10: 427-515 (March) 1925

*Myocardial Infarction: Electrocardiographic Study. F. A. Willius and A. R. Barnes, Rochester, Minn.—p. 427.
Physical and Colloidal Chemistry of Arsphenamin. Part II. Alkalinized Solution of Arsphenamin. A. S. Hunter and W. A. Patrick, Baltimore.—p. 446.
*Pharmacodynamic Study of Anthelmintic Properties of Two Oils of Chenopodium. A. R. Bliss, Jr., Memphis, Tenn.—p. 456.
*Leukocytic Phase of Hemoclastic Shock. W. S. Middleton and E. Thewlis, Madison, Wis.—p. 462.
*Distribution of Phosphorus Compounds in Blood in Tuberculosis. K. L. McCluskey, Chicago.—p. 466.
Destruction of Complement in Human Serum by Heating. G. E. Davis, Mobile, Ala.—p. 475.
Case of Fibroid Gumma. S. S. Greenbaum, Philadelphia.—p. 476.
*Uric Acid Levels in Blood of Man and Animals. A. T. Weathers and H. C. Sweany, Chicago.—p. 480.
Better Postmortem Service. H. E. Robertson, Rochester, Minn.—p. 486.

Myocardial Infarction.—Nine new cases are reported, and twenty-four published cases are reviewed by Willius and Barnes. The most constant and striking changes occurring in the electrocardiograms were those affecting the T wave; such abnormalities occurred in eight cases. The most frequent change was the negativity of the T wave involving Derivation I, combined Derivations I and II, combined Derivations II and III, and combined Derivations I, II and III. In three cases, the derivations involved varied during the period of observation. In two cases, a tendency for fusion of the R and T wave occurred as a transient manifestation, and quite closely resembled the findings described by Pardee. Notching and broadening of the Q-R-S complex involving all derivations occurred in only one instance, at first affecting only Derivations I and II, but ultimately involving all derivations. In one case a paroxysm of nodal tachycardia occurred preceding death, and in another case auricular flutter and nodal tachycardia. The electrocardiogram was normal in only one case.

Oil of Chenopodium an Anthelmintic.—This study by Bliss shows that oil of chenopodium, properly distilled from plants cultivated in the Middle Western states, is as efficacious in dogs against ascarids as is the Maryland oil of chenopodium.

Hemoclastic Shock.—While no conclusion is drawn by Middleton and Thewlis, the indication is clear that a protein element is not essential for the production of hemoclastic shock in cases of catarrhal cholangeitis.

Phosphorus Metabolism in Tuberculosis.—There is a disturbance in phosphorus metabolism in tuberculosis. McCluskey's studies show that a decrease in lecithin content of both the cell and the plasma with simultaneous increase in acid soluble phosphorus represents a grave prognosis, while the opposite indicates a favorable condition. Since the decrease in lecithin is accompanied by an increase in acid soluble phosphorus, it would appear that the latter fraction may be utilized for the synthesis of lecithin. In the advanced stages of tuberculosis there may be a destruction of lecithin or an inability to synthesize it, occasioned by a lack within the body of fatty acids, the cholin residue, glycerol or, perhaps, specific enzymes. The size of the red cell is decreased in tuberculosis, except in the first stages, and the percentage by volume of cells is decidedly decreased in the far advanced exudative type.

Uric Acid Levels.—Weathers and Sweany are of the opinion that the normal level for uric acid in the blood should

be raised from 1 to 3 mg. to 1 to 4 mg. per hundred cubic centimeters of blood. Uric acid content of bloods in all stages of tuberculosis is about normal, with a very slight actual as well as relative decrease in the far advanced stages. The Folin-Wu test does not give results equal to the total amount of uric acid in the blood. Folin's and Benedict's latest methods give the same results, and each give a fairly accurate recovery of uric acid added to human or animal blood. Polyphenols and amino-acids, in quantities double those found in normal blood, do not make appreciable error in uric acid determinations by the Folin or Benedict methods.

Journal of Pharmacology and Experimental Therapeutics, Baltimore

25: 91-174 (March) 1925

Studies of Intoxication. I. Action of Nitrous Oxid. B. M. Davidson, Aberdeen, Scotland.—p. 91.

25: 175-273 (April) 1925

Action of Quinin on Protein Metabolism, Respiratory Exchange and Heat Function. II. Respiratory Exchange and Heat Function. S. W. Hardikar.—p. 175.

*Effect of Phenobarbital (Luminal) and Sodium Phenobarbital (Luminal-Sodium) on Blood Pressure and Respiration. C. M. Gruber and R. F. Baskett, St. Louis.—p. 219.

Quantitative Study of Absorption and Excretion of Anthelmintic Dose of Carbon Tetrachlorid. H. S. Wells, Baltimore.—p. 235.

Effect of Phenobarbital on Blood Pressure.—Administration of sodium phenobarbital and phenobarbital in moderate doses (0.05 to 0.5 gm.) caused a fall in blood pressure in 162 out of 164 cases studied by Gruber and Baskett. Sodium phenobarbital in small and moderate doses caused accleration of respiration with decreased depth in most instances. In one case a slowed respiration only was noted. Small and moderate doses of sodium phenobarbital usually cause, after the temporary acceleration, a slowed rate and increased depth of respiration. Large doses of sodium phenobarbital and phenobarbital cause paralysis of respiration. The heart continues to beat for some seconds, even minutes, after cessation in respiration.

Journal of Urology, Baltimore

13: 257-382 (March) 1925

*Prerenal Anuria. A. Randall, Philadelphia.—p. 257.

*Postrenal Anuria. J. R. Caulk, St. Louis.—p. 265.

Glomerular Circulation. A. N. Richards, Philadelphia.—p. 283.

Malignant Papillomata of Renal Pelvis Associated with Solitary Cyst of Kidney. E. O. Swartz, Cincinnati.—p. 295.

Bilateral Ectopic Kidneys. C. M. Harpster, Toledo, Ohio.—p. 309.

*Results of Decapsulation of Kidney for Nephritis. W. C. Quinby, Boston.—p. 321.

Congenital Dilation of Ureter. N. F. Ockerblad, Kansas City, Mo.—p. 325.

Satisfactory Method of Aseptic Ureteral Catheterization. W. Grant, Louisville.—p. 329.

Paralysis of Bladder with Acute Poliomyelitis. H. G. Bugbee, New York.—p. 333.

*Heart in Prostatic Hypertrophy. F. A. Willius, Rochester, Minn.—p. 337.

Technic for Handling Prostatic Carcinoma. W. M. Watson and C. C. Herger, Buffalo.—p. 343.

Diathermy: New Technic for Treatment of Carcinoma of Prostate. B. C. Corbus, Chicago.—p. 355.

Sterility in Male. F. R. Hagner, Washington, D. C.—p. 377.

Prerenal Anuria.—It is Randall's firm belief that hypotension is a most important danger in the preoperative and postoperative periods of all urologic cases, and that blood pressure readings are as essential a part of the ward routine as any of the renal function tests. The fluid intake is important and should be liberal. Alimentary absorption appears preferable to other modes of administration. The avoidance of, or the removal of, any and all possible factors that may stimulate splanchnic inhibition is imperative. Care in the administration of renal depressant drugs, especially pituitary extract, and likewise opiates, is indicated. The anuric state of prerenal origin, when once established, should be handled by observing all these factors, and, in addition, it may be combated actively by vesical distention and rapid evacuation, as a stimulant to diuresis; bilateral ureteral catheterization, which in all probability breaks an inhibitory arc, acting as the cause of the anuria; and renal decapsulation.

Postrenal Anuria.—Among 280 personal cases of renal and ureteral stones, Caulk has seen anuria six times; also in three cases of ureteral ligation complicating pelvic surgery and in one case of cancer infiltration of the pelvis from extensive uterine disease. Sucess in the treatment of anuria depends on familiarity with the condition causing it, realization of its seriousness, in spite of the comparatively good clinical condition of the patient, and prompt therapeutic response. Expectant treatment should have a meager place in cases of calculus anuria; with proper cystoscopic manipulations, a fair number of stones may be removed, hence, the anuria is completely relieved. In case of inability to successfully and promptly unblock the obstruction by cystoscopic technic, the surgeon of judgment, not deceived by the patient's apparently safe condition, will promptly remove the offending stone or stones. The nature of the surgery depends on the location and character of the calculus.

Decapsulation of Kidney for Nephritis.—Three cases are reported by Quinby: One a case of hemorrhagic nephritis, one of acute tubular nephritis from mercuric chlorid poisoning, and one of chronic glomerular nephritis with edema. After bilateral decapsulation these cases were followed carefully with respect to their blood chemistry, as well as other more general observations, and in none of them was any benefit whatever, not even of a temporary character, to be demonstrated.

Heart in Prostatic Hypertrophy.—Willius reports the results of a study from the cardiovascular standpoint, including electrocardiographic investigation, of 705 patients with prostatic hypertrophy. Two hundred and ninety-three had cardiovascular disease. The arteriosclerotic type of cardiac disease occurred with the greatest frequency, 125 times. One hundred and six of the patients had arteriosclerotic cardiac disease associated with hypertension. Hypertensive cardiac disease occurred in fifty cases, unassociated with outstanding arteriosclerotic features. Other types of cardiac disease occurred in 4 per cent. of the cases, and included three cases of chronic rheumatic endocarditis with mitral stenosis, two cases of chronic rheumatic endocarditis with mitral regurgitation, one case of aortic regurgitation of the arteriosclerotic type, one of aortic stenosis, one of syphilitic aortitis, one of myocardial degeneration associated with exophthalmic goiter, two cases of adenomatous goiter with hyperthyroidism, and one case of chronic adherent pericarditis and of acute fibrinous pericarditis, respectively. Twenty-two patients had angina pectoris, in one case associated with syphilitic aortitis.

Laryngoscope, St. Louis

35: 181-258 (March) 1925

Synergistic Analgesia as Employed in Cases About Head and Neck. J. C. Beck, H. L. Pollock and F. L. Lederer, Chicago.—p. 181.

Syngergistic Analgesia in Head Surgery with Special Reference to Novocain, Magnesium Sulphate and Morphin. J. J. King, New York.—p. 200.

Unsuspected Case of Otitic Cerebellar Abscess. Operation and Recovery. E. T. Gatewood, Richmond, Va.—p. 203.

Radical Mastoidectomy. E. B. Dench, New York.—p. 205.

Time Relations of Tuning-Fork Hearing with Fork at Different Locations. D. MacFarlan, Philadelphia.—p. 208.

Streptococcus Hemolyticus in Tonsilar Crypts. C. C. Eves and W. R. Watson, Philadelphia.—p. 210.

Eustachian Tubal Curettage. S. Yankauer, New York.—p. 215.

Blindness from Teeth, Tonsils and Accessory Sinuses. L. E. White, Boston.—p. 217.

Bronchoscopy in Treatment of Asthma; Twenty-One Cases. R. M. Lukens, Philadelphia.—p. 227.

Two Cases of Vincent's Angina Following Tonsillectomy. G. M. Van Poole, Honolulu.—p. 235.

Medical Journal and Record, New York

70: 325-388 (March 18) 1925

Eugenic Program; How Far Is It Practical? T. Diller, Pittsburgh.—p. 325.

Outlook for Tuberculosis Patient. H. C. Sweany, Chicago.—p. 327.

Indications for Suspension Laryngoscopy. R. H. T. Mann, Texarkana, Arkansas-Texas.—p. 333.

Clinical Interpretation of Pain. B. Lipshutz, Philadelphia.—p. 334.

Wassermann Control by Diet in Specific Types. W. E. Kernan, Boston.—p. 337.

Rural School Medical Inspection. L. A. Hulbert, Springville, N. Y.—p. 338.

Artificial Pneumarthrosis As Aid in Diagnosis. S. Kleinberg, New York.—p. 341.

Common Duct Complications After Gallbladder Surgery. J. W. Winston, Norfolk, Va.—p. 343.

Combined Right Inguinal Hernia and Appendix Operation. H. Cohen, New York.—p. 345.
New Specific Therapy in Collapse. K. Peters, Woodside, N. Y.—p. 346.
Therapeutic Notes. C. G. Cumston, Geneva, Switzerland.—p. 347.
Present Day Management of Uncomplicated Labor. J. P. Greenhill, Chicago.—p. 349.
Clinical Aspects of Abortions. P. F. Williams, Philadelphia.—p. 353.
Eye Changes in Pregnancy. J. W. Wheeler, New York.—p. 355.
Gonorrhea in Women. B. Mann, Philadelphia.—p. 356.
Inflammatory Disease of Cervix Uteri. J. F. McGrath, New York.—p. 360.
Rubin Test and Its Modifications in Female Sterility. A. Jacoby, New York.—p. 362.
Pregnancy with Complications. D. H. Bessesen, Minneapolis.—p. 364.

121: 389-452 (April 1) 1925

Surgical Injuries of Ureter. P. B. Bland, Philadelphia.—p. 389.
Local Anesthesia in Tuberculous Patient. R. E. Farr, Minneapolis.—p. 392.
Medical Work in Syria. J. W. Shuman, Los Angeles.—p. 394.
Rôle of Electron in Roentgen Ray and Radium Therapy. D. C. A. Butts, Philadelphia.—p. 397.
Experimental and Clinical Evidence Supporting Action of Secondary Radiations from Roentgen Tube in Treatment of Malignant Processes. J. W. Frank, Philadelphia.—p. 403.
Case of Lateral Sinus Thrombophlebitis. A. Weizenhoffer, New York.—p. 406.
Occluded Fallopian Tube and Its Relation to Cervical Infection. I. Smiley, New York.—p. 407.
Basis and Development of Systematic Respiratory Therapy. L. Hofbauer, Vienna, Austria.—p. 410.
*Height and Duration of Fever in Relation to Clinical Outcome in Treatment of General Paresis with Malaria. H. A. Bunker and G. H. Kirby, New York.—p. 413.
Treatment of Paresis by Malarial Infection. G. B. Lake, Chicago.—p. 415.
General Paresis and Its Treatment with Malaria. H. Goodman, New York.—p. 417.
Psychoneuroses in Relation to General Medicine. A. Gordon, Philadelphia.—p. 419.
Postoperative Neuroses. P. R. Lohrman, New York.—p. 422.
Psychiatric Clinic and General Hospital. C. P. Oberndorf, New York.—p. 424.
Treatment of Peripheral Nerve Paralysis with Diathermy. A. Lux, New York.—p. 427.

Malaria Treatment of General Paresis.—Four of the patients with general paresis reported on by Bunker and Kirby have achieved good remissions, two of these excellent remissions (all of them now of more than a year's duration), in whom a temperature of 105 F. was maintained for a total period of not more than from five to seven hours; while in twelve such patients this total period did not exceed seventeen hours, being materially shorter than this in seven of these twelve cases. The authors conclude that a temperature of 105 F. maintained over a total period of not more than from twelve to eighteen hours will give rise to a favorable outcome, among unselected cases of general paresis, as readily (and with proportionately diminished risk to the patient) as an equal or greater degree of pyrexia maintained over a greater number of hours.

New York State Journal of Medicine, New York

25: 555-594 (April 3) 1925

*Causes of Death at Childbirth. O. R. Eichel, Albany.—p. 555.
Hysteria. S. Block, Brooklyn.—p. 560.
*Infections in Tonsils and Paranasal Sinuses in Series of Cardiac Patients. R. W. Hawkins, Rochester.—p. 566.
Clinical Uses of Cisternal Puncture. A. S. Chittenden, Binghamton.—p. 568.
Community Provision for Mental Illness. F. W. Parsons, Buffalo.—p. 570.

Causes of Death at Childbirth.—The death rate from causes connected with childbirth in New York City ranged between 44 and 70; and in New York State, outside of New York City, it varied from 53 to 83. Puerperal sepsis comprised 27 per cent. of these deaths in the entire state, 25 per cent. in New York City and 30 per cent. in the rest af the state. The prevention of death in the remainder of the cases would seem to depend mostly on the education of the public; adequate clinical and hospital facilities for the care of the poor and those of moderate means; measures to make available, if possible, expert obstetric advice for physicians in remote rural districts, or facilities for early removal of abnormal cases to the obstetric expert; elevation of the standards of obstetric training and practice for physicians, and clinical, pathologic, and statistical research to discover facts at present unknown, and to determine the routes of puerperal infection.

Infected Tonsils in Cardiac Cases.—According to Hawkins in a series of 215 cardiac cases examined routinely at the adult cardiac clinic of Bellevue Hospital, infected tonsils were found in 52.8 per cent. of cases, and purulent sinusitis in 6 per cent. In a group of cases with rheumatic cardiac disease, 62 per cent. had infected tonsils, as compared with 29 per cent. in a control series of the same ages.

25: 599-636 (April 10) 1925

Diagnosis of Acute Surgical Diseases of Abdomen. H. Roth, New York.—p. 599.
Fractures of Humerus. H. E. Santee, New York.—p. 606.
Present Day Tendencies of Practice of Medicine. E. C. Reifenstein, Syracuse.—p. 608.
Value of Educational Campaign in Promoting Early Diagnosis of Pulmonary Tuberculosis. H. Golembe, Liberty.—p. 612.
Headache of Nasal Origin. G. Huntchison Cox, Glen Cove.—p. 616.

25: 637-674 (April 17) 1925

Urologic Diagnosis. M. Zigler, New York.—p. 637.
Schistosoma Hematobium Infection; Relation to Persistent Urinary Sinus. W. S. Pugh, New York.—p. 643.
Laboratory Aids in Diagnosing and Treating Nephritis. H. N. Cooper, Watertown.—p. 646.
Undergraduate Deficiencies and Postgraduate Requirements. E. R. Stitt, Washington, D. C.—p. 650.
Breast Feeding. F. H. Richardson, Brooklyn.—p. 653.

25: 675-712 (April 24) 1925

Twenty-Five Years' Progress in Medical Education in Internal Medicine and Medical Specialties. S. W. Lambert, New York.—p. 675.
*Vaccination and Smallpox. F. W. Sears, Syracuse, N. Y.—p. 681.
*Chronic Otorrhea in Insane. J. D. Whitham, New York.—p. 684.
Treatment of Congenital Deformities. R. Stephens, New York.—p. 686.
Infant Feeding. R. Sheldon, Lyons, N. Y.—p. 688.
Fractures of Upper End of Humerus. J. N. Worcester, New York.—p. 691.

Vaccination and Smallpox.—Sears calls attention to certain facts regarding the increased prevalence of smallpox throughout the United States and to some of the causes responsible for its spread, and urges the more general adoption of the improved methods in vaccination.

Chronic Otorrhea in Insane.—Four of the seven insane patients on whom Whitham operated for aural suppuration showed marked mental improvement, two showed considerable improvement, and in two patients the operation did nothing to arrest the progress of the disease. In all cases the operation cured the aural suppuration. There is no intention to claim directly or by inference that any patients were cured of insanity, but the mental improvement after operation was striking in some of the cases.

Radiology, St. Paul

4: 173-264 (March) 1925

Key Points in Lung Structure. W. S. Miller, Madison, Wis.—p. 173.
Roentgen-Ray Shadows of Secondary Infection in Lung Tuberculosis. H. P. Mills and W. W. Watkins, Phoenix, Ariz.—p. 173.
Applied Pathology of Pulmonary Tuberculosis. K. Dunham and J. H. Skavlem, Cincinnati.—p. 181.
Realtionship of Radiologic Diagnosis of Tuberculosis of Lungs to Clinical Diagnosis. J. J. Waring, Denver.—p. 188.
*Pathognomonic Radiographic Finding in Early Pulmonary Tuberculosis. I. S. Trostler and R. H. Hayes, Chicago.—p. 196.
Roentgen Ray and Clinical Study of Some Pulmonary Lesions. M. Kahn and M. F. Sloan, Baltimore.—p. 198.
Pleural Effusions, Detection and Differentiation by Roentgen Ray. W. H. Stewart, New York.—p. 209.
New Growths of Lung, Primary and Secondary. L. T. LeWald, New York.—p. 212.
Acute Consolidations of Lung. L. R. Sante, St. Louis.—p. 221.
Oral Roentgen-Ray Diagnosis. F. F. Molt, Chicago.—p. 242.
Radioactive Substances and Their Therapeutic Uses and Applications. J. Muir, New York.—p. 246.

Roentgen-Ray Diagnosis of Pulmonary Tuberculosis.—Following the injection of tuberculin, Trostler and Hayes make roentgenograms of the lungs. When there is a reaction, there is an increase in the density in the area where the focus of tuberculosis has taken on the congestion produced by the tuberculin reaction, the lymphatics around infected tuberculous glands show an infiltration around them, and there are usually found areas where there is a slightly increased density, where lesser degrees of involvement are present. This is in no way an activation of an old, healed tuberculous lesion, but it is a sort of stimulation to new energy of the focus to help throw off the infection. This focal reaction,

being produced by the action of tuberculin, is a specific reaction and is diagnostic of tuberculosis.

Surgery, Gynecology and Obstetrics, Chicago

60: 449-592 (April) 1925

*Condition Sometimes Called Leather-Bottle Stomach. S. Wyard, London, England.—p. 449.
*Polyposis of Colon. J. F. Erdmann and J. H. Morris, New York.—p. 460.
Plastic Surgery of Nose. G. W. Pierce, San Francisco.—p. 469.
Extradural Liposarcoma of Spinal Canal. J. A. Caldwell and M. M. Zinninger, Cincinnati.—p. 476.
*Method for Localization of Brain Tumors; Pineal Shift. H. C. Naffziger, San Francisco.—p. 481.
Plan for Early Diagnosis and Management of Primary Papilloma of Ureter and Kidney Pelvis. R. V. Day, F. D. Fairchild and H. W. Martin, Los Angeles.—p. 485.
*Effect of General Anesthetics on Organism as a Whole. W. de B. MacNider, Chapel Hill, N. C.—p. 493.
Left Sided Abdominal Abscess as Complication of Appendicitis. C. Nather and A. Ochsner, Chicago.—p. 495.
*Primary Carcinoma of Kidney: Case. J. L. Dies, Rochester, Minn.—p. 499.
Actinomycosis of Ovary and Tube. F. C. Helwig, Kansas City, Kan.—p. 502.
Catilaginous Tumors of Bone. V. H. Keiller, Galveston, Texas.—p. 510.
Fractures of Foot. L. Dretzka, Detroit.—p. 522.
Diverticulum of Bladder Causing Dystocia at Labor. W. L. Wolfson, Brooklyn.—p. 524.
Embryonic Rests of Urinary Bladder. F. H. Bolby, Boston.—p. 528.
Cytologic Examination of Urine as Aid to Diagnosis of Tumors of Genito-Urinary Tract. F. J. Parmenter, Buffalo.—p. 531.
Undescended Testicle. S. G. Sonneland, Cleveland.—p. 535.
*Entrance of Bile Into Duodenum. A. Winkelstein, New York.—p. 545.
Insulin-Glucose Treatment of Surgical Shock and Nondiabetic Acidosis. D. Fisher and E. Mensing, Milwaukee.—p. 548.
Diphtheria Vaginitis: Two Cases. A. F. Lash, Chicago.—p. 556.
*Method for an End-to-End Gastrojejunostomy After Partial Gastrectomy. T. S. Moise and S. C. Harvey, New Haven, Conn.—p. 559.
Useful Mechanical Aids in Treatment of Fractures of Spine. F. Christopher, Winnetka, Ill.—p. 562.
New Form of Ligature Needle. H. S. Souttar, London, Eng.—p. 565.
Modification of Clavicular Cross. B. B. Landry, Hartford, Conn.—p. 566.
Simple Silver Point Cautery. R. L. Dickinson, New York.—p. 567.
*Chronic Endocervicitis; Treatment with Electric Cautery. C. H. Davis, Milwaukee.—p. 568.
Treatment of Chronic Gonorrhea in Women with Electric Cautery. H. W. Shutter, Milwaukee.—p. 572.
*New Method for Removal of Stone in Ureter. A. B. Illievitz, Montreal.—p. 575.

Leather Bottle Stomach.—Wyard states that leather bottle stomach is neither a clinical nor a pathologic entity and is a name that should be abandoned as serving no useful purpose. The controversy as to its nature, whether simple or malignant, is also settled, since it may be either the one or the other. Diffuse fibromatosis or diffuse carcinomatosis are suitable names which aptly designate the two conditions included by the original term.

Polyposis of Colon.—For purposes of standardization, it is suggested by Erdmann and Morris that the term "polyposis of the colon" be limited to designate an adenomatous hyperplasia of the intestinal mucous membrane as opposed to those polypoid tumors of the intestine which are histologically fibromata, myomata, etc.

Localizing Brain Tumors.—Naffziger has found that the pineal shift as determined by roentgen-ray examination will frequently localize a brain tumor. This method has been of great value in confirming opinions based on neurologic examination, and it alone has frequently made the diagnosis possible. The shift has been found with brain tumors, brain abscess and in certain cases of brain swelling consequent on a vascular block. A position of the pineal gland to the right of the midsagittal plane indicates a left sided lesion above the tentorium. A position of the pineal to the left of the midsagittal plane indicates a right sided lesion above the tentorium. A position of the pineal in the midsagittal plane in the presence of intracranial pressure indicates equal pressure on the two sides. In the chronic form of intracranial pressure as due to tumor or abscess, this means internal hydrocephalus. This has been found occurring in lesions of the posterior fossa and distortion of the third and fourth ventricles.

Effect of General Anesthetics on Whole Organism.—MacNider's experiments show that ether is more toxic for an old organism than for a young organism. This toxicity is first expressed by the anesthetic substance inducing such a change in the physicochemic state of the blood that one organ at least, the kidney, is furnished a blood of such altered composition that it fails to functionate in a normal fashion. It would appear that, prior to the use of an anesthetic in an aged patient, the organism should be protected against the anesthetic by the use of a diet rich in carbohydrates and by the judicious use of sodium bicarbonate, in order to maintain during the anesthesia a normal acid-base equilibrium of the blood.

Primary Carcinoma of Kidney.—Dies reports the case of a girl, aged 4, who was brought to the hospital because of a large swelling in the abdomen. She had previously been in fair health, although never quite as robust as the average child of her age. Three months before hospitalization, the mother had first noticed that the child's abdomen was becoming hard. This hardness increased steadily, and, at the time of examination, there was a mass measuring about 17.5 by 10 cm. The growth was removed under gas ether anesthesia. The child died a few hours later without regaining consciousness. The pathologist reported adenocarcinoma of the kidney.

Entrance of Bile Into Duodenum.—Observations on some experimental studies on the entrance of bile into the duodenum are reported on by Winkelstein. Apparently, an increase in intra-abdominal pressure squeezes bile out of the gallbladder into the duodenum when the sphincter of Oddi is relaxed. It is suggested that, in addition to relaxing the sphincter of Oddi by the administration of magnesium sulphate, manual and other methods (coughing, bending and deepened respiration) to increase the intra-abdominal pressure may prove to be of value in obtaining bile from the gallbladder of patients.

End-to-End Gastrojejunostomy.—In contrast with the usual procedures used after a partial gastrectomy which are end-to-side or side-to-side methods, the procedure described by Moise and Harvey is an end-to-end anastomosis and should have the mechanical and physiologic advantages that are inherent in the end-to-end anastomosis. In contrast with the Polya type of gastrojejunostomy, they avoid cutting the circular muscle fibers over a wide area, and there is no opportunity for the formation of an atonic dilated pouch at the site of the stoma. After this operation is completed, the two loops of jejunum naturally gravitate downward, which is the optimum position for the maintenance of a patent stoma, while this same tendency for the loops to drop down after the Polya anastomosis may tend to kink and partly occlude the opening.

Electric Cauterization in Endocervicitis.—In 155 consecutive cases of endocervicitis treated by Davis by other than local applications, eighteen had a cervical operation, thirty-one were cauterized under anesthesia at the hospital and 106 without anesthetic at the office. The condition has been improved in every case, and healing has occurred usually in about six weeks. A few patients required subsequent cauterization. In two cases the cervical leukorrhea while improved is not entirely relieved. Stricture of the cervix has not followed treatment in any case. Two patients who had extensive cauterization under anesthesia have been delivered without difficulty. Davis' observations suggest that the infection and resulting changes are limited at first to the glands near the external os. This is especially true in erosions developing during the puerperium. A single superficial cautery treatment about eight weeks after delivery usually results in prompt healing within about three weeks. This more or less prophylactic measure should prevent most of the severe chronic conditions of the cervix which tend to develop after childbirth. It is believed that electric cauterization with a light cautery tip is the method of choice in most cases which have no other indication for surgery.

Removing Ureteral Stone by Inflation.—By means of repeated inflations of the ureter through a catheter passed up to the stone, and the gradual withdrawal of the catheter, the stone follows it downward and eventually drops into the bladder, from which it is easily removed. The method is in the experimental stage. It has not yet been tried on the human.

FOREIGN

An asterisk (*) before a title indicates that the article is abstracted below. Single case reports and trials of new drugs are usually omitted.

British Medical Journal, London

1: 723-764 (April 18) 1925

*Mortality of Appendicitis. J. E. Adams.—p. 723.
*Appendicitis. J. Sherren.—p. 727.
*Anoxemic Type of Infantile Atrophy. C. A. Botwood, H. S. Raper and E. Willock.—p. 730.
*Method of Treating Infected Ulcers. S. A. Pfannenstill.—p. 732.
Tracheotomy Tube Worn for Over Sixty Years. R. Woods.—p. 733.
Diphtheria in Old Age. G. W. Ronaldson.—p. 733.
Chorea in Infancy: Case. H. Armstrong.—p. 734.
Spontaneous Rupture of Heart. M. Cohen.—p. 734.
Traumatic Intussusception. D. A. Mitchell.—p. 734.
Long Survival with Cancer of Breast. J. Bernstien.—p. 734.

Mortality of Appendicitis.—Adams reviews incidence and mortality figures of appendicitis from the leading hospitals and poor law institutions in the London district down to 1922. The hospital cases show slight diminution since 1912, and the infirmary figures a definite increase. The explanation of this turnover from hospital to infirmary is that the general practitioner, realizing the urgency of cases of appendicitis and the lack of empty beds in the hospitals, prefers to send his cases where he knows they will be admitted without delay.

Appendicitis.—Sherren draws attention to the necessity of early operation in cases of acute appendicitis and to the care necessary in their diagnosis; and warns against too readily diagnosing chronic appendicitis; it is a disease that does exist and cause symptoms, but is not nearly as common as is often supposed.

Anoxemic Type of Infantile Atrophy.—Botwood, Raper and Willock discuss a form of atrophy which fails to respond to dietetic, endocrine or vitamin treatment. They tried the effect of oxygen administration in these cases. The results obtained have been promising. The cases chosen for oxygen treatment have been those which, after a period of dietetic treatment, have shown themselves to be refractory, as judged by failure to gain weight. When failure to gain in weight was established, and the child was still on a diet to which it had not responded, the oxygen treatment was commenced. Thereafter the composition of the diet was not changed, but increased amounts of food were given as necessitated by the increase in weight and appetite of the child.

Treatment of Ulcers.—The treatment employed by Pfannenstill consists of the use of sodium iodid, administered orally, and hydrogen peroxid locally, acidified with a small quantity of an acid. Pfannenstill generally uses acetic acid, but employs boric acid in treatment in the mouth, thus avoiding injury to the teeth.

Journal of Pathology and Bacteriology, Edinburgh

28: 133-396 (April) 1925

*Experimental Soot Cancer. R. D. Passey and J. Carter-Braine.—p. 133.
*Influence of Fat-Soluble Accessory Food Factor on Initiation of Soot Cancer in Mice. R. D. Passey and J. L. Woodhouse.—p. 145.
Indirect Evidence that Anaerobes Tend to Produce Peroxid in Presence of Oxygen. J. W. M'Leod and J. Gordon.—p. 147.
Relations Between Reducing Powers of Bacteria and Their Capacity for Forming Peroxid. J. W. M'Leod and J. Gordon.—p. 155.
Estimation of Urea in Blood by Hypobromite Method. F. S. Fowweather.—p. 165.
Flocculation Test for Syphilis. H. F. Watson.—p. 171.
*Arthritic Muscular Atrophy. A. E. B. Harding.—p. 179.
Growth of Branching Forms of Bacilli ("Three Point Multiplication"). A. D. Gardner.—p. 189.
*Adenomyoma of Stomach. M. J. Stewart and A. L. Taylor.—p. 195.
Investigation of Phytopathogenic Bacteria by Serologic and Biologic Methods. R. John-Brooks, K. Nain and M. Rhodes.—p. 203.
*Correlation Coefficients of Urine with Reference to Cancer. C. P. White.—p. 211.
Renal Circulation Rate in Experimental Oxalate Nephritis. J. S. Dunn, J. H. Dible, N. A. Jones and B. A. McSwiney.—p. 233.
*Diphtheria Antitoxin in Blood of Normal Horses. A. T. Glenny.—p. 241.
Dosage and Death-Time. A. T. Glenny.—p. 251.
Time of Combination of Diphtheria Toxin with Living Tissues. A. T. Glenny and B. E. Hopkins.—p. 261.
*Antigenic Effect of Intravenous Injection of Diphtheria Toxin. A. T. Glenny and C. G. Pope.—p. 273.
*Measurement of Combining Power of Diphtheria Toxin and Toxoid with Antitoxin in Relation to Their Antigenic Efficacy. A. T. Glenny, C. G. Pope and H. Waddington.—p. 279.
Effect of Serum-Sensitiveness and Precipitin Formation on Efficacy of Diphtheria Toxoid and Toxinantitoxin Mixtures in Promoting Antitoxin Production. A. T. Glenny, B. E. Hopkins and H. Waddington.—p. 305.
Titration of Diphtheria Toxin by Flocculation Method. A. T. Glenny and U. Wallace.—p. 317.
Immunologic Notes. A. T. Glenny, C. G. Pope, H. Waddington and U. Wallace.—p. 333.
Group Agglutination of Bacilli. II. Absorption of Agglutinin in Diphasic Salmquellas. F. W. Andrewes.—p. 345.
*Pathologic Classification of Goiter. G. S. Williamson and I. H. Pearse.—p. 361.
*Ruptured Aneurysm of Basilar Artery at Age 17. J. B. Duguid.—p. 389.
*Unusually Large Cardiac Aneurysm. T. Shennan and W. Niven.—p. 390.
Multiple Cystic Liver: Case. C. R. Burns.—p. 392.
*Carcinoma of Jejunum. P. P. Lynch.—p. 394.

Experimental Soot Cancer.—An active fraction, fraction 2, has been prepared by Passey and Carter-Braine from soot, consisting mainly of its ether-soluble bases, which will produce cancer readily in mice. On further fractionation of this, carcinogenetic factors are distilled over in the fractions boiling above 190 C. under a pressure of 20 mm.

Effect of Vitamin A on Experimental Cancer.—Experiments made by Passey and Woodhouse indicate that the presence or absence of the fat-soluble A factor would seem to have no effect on the induction of new growths by soot.

Arthritic Muscular Atrophy.—Characteristic arthritic muscular atrophy has been produced in rabbits and the conditions of its occurrence examined.

Adenomyoma of Stomach.—The adenomyomas of the stomach described by Stewart and Taylor belong to Lauche's fourth group. They are derived from similar embryonic epithelial buds, but unlike the pancreatic heterotopias they show a varied structure owing to the fact that a large part of the nodule remains undifferentiated while differentiation when it occurs takes place in two directions, pancreatic and gastro-intestinal. Each of the four reported cases shows this combination of pancreatic tissue and glandular tissue of gastro-intestinal (secretory) type, and in each the undifferentiated (ductlike) tissue, of definitely neoplastic aspect, is considerably in excess of the other two combined. All four have unstriped muscle as an integral part of their composition. Three of the patients were operated on for recurring attacks of pain of "duodenal" type; i. e., coming on during the later stages of digestion, and relieved by taking more food. At operation, two of the cases were provisionally diagnosed as being malignant, and partial gastrectomy was performed; in the third case, local excision was practiced. It is obvious to the authors that as a condition of clinical importance, adenomyoma of the stomach is of very infrequent occurrence, but it is perhaps well that operating surgeons should be aware of its existence, and should be prepared to treat it when possible by local excision rather than by extensive gastric secretion.

Correlation Coefficients of Urine with Reference to Cancer.—More than 4,000 coefficients for the daily amounts of urine were calculated by White. The method appears to be of considerable value and would probably lead to important results if, for instance, it were applied to determining such questions as the associations of glucose in diabetes, etc. It could be applied to any form of metabolism investigations. The only objection to the method is the amount of labor involved in the calculations which increases rapidly with the number of variables taken into account: with three variables the total number of coefficients is six, with four it is twenty-four, with five it is eighty and so on. The great advantage of the method is that it gives a quantitative measurement of the degree to which two variables are associated.

Diphtheria Antitoxin in Normal Blood.—As is well known, many horses never subjected to artificial immunization have diphtheria antitoxin in their blood. Thus, while 0.01 c.c. of an ordinary brew of strong diphtheria toxin would seriously affect or even kill many normal horses, others contain so much normal antitoxin that 10 c.c. of the same toxin would not harm them. Horses possessing natural antitoxin in their blood produce antitoxin rapidly; those with no normal immunity do not respond rapidly to immunization. The source of natural immunity possessed by some horses

has never been satisfactorily identified. Of 1,350 horses tested by Glenny on admission during seventeen years, about half contained 0.1 unit or more antitoxin per cubic centimeter. The percentage of horses possessing normal immunity has greatly decreased in recent years. Horses possessing normal immunity showed considerable fluctuations of antitoxic titer while under observation though no injection of diphtheria toxin had been given. The source of the stimulus was not found.

Antigenic Effect of Diphtheria Toxin.—Glenny and Pope state that the intravenous injection of diphtheria toxin antitoxin mixture produces a primary stimulus response in normal rabbits. Unneutralized modified toxin injected intravenously is less effective than the same toxin partially neutralized. The intravenous injection of diphtheria toxin can act as a secondary stimulus.

Units of Measurement of Diphtheria Toxin.—The different units of measurement of toxin are discussed by Glenny, Pope and Waddington; it is pointed out that only the flocculation test is a true measure of the combining capacity of a toxin. The indicating mixture, or mixture containing the "precipitate indicateur," consists of exact equivalents of toxin plus toxoid and antitoxin. Antitoxin has a greater affinity for toxin than for toxoid. Toxin and antitoxin can dissociate from combination: the amount of dissociation which takes place in a mixture may vary with different sample of antitoxin. Both specific toxin and toxoid are antigenic.

Pathologic Classification of Goiter.—A classification of the pathologic states of the thyroid has been made by Williamson and Pearse based on a new conception of the morphology and function of the organ. Known pathologic entities in the thyroid are referred to their point of departure from the normally functioning organ, and certain new pathologic entities are described and their probable clinical manifestations indicated. Exophthalmic goiter is shown to be of two types: primary, associated with adenoid goiter; secondary, with a primary arteriocapillary sclerosis of the gland. "Hyperthyroidism" is shown to be a dysthyroidism with a definite histologic basis. Exophthalmic goiter in both its forms is something more than a simple dysthyroidism. A vesicular goiter is described as a distinct entity and the histologic obverse of adenoid goiter. The condition is probably a true hypothyroidism. Under hyperplastic goiter two states are defined: one referable to an anatomic deficiency, the other, lymphadenoid goiter, to a physiologic deficiency in the gland. The relation of each to certain neoplastic growths is suggested. Certain types of tumefaction are shown to be retrogressive conditions, the morphologic basis of which is demonstrated.

Ruptured Aneurysm of Basilar Artery.—Duguid relates the case of a farm hand, aged 17, apparently in robust health, who collapsed one morning at his work into a "fainting fit." He was immediately carried to bed where he remained for four days, when he was able to travel to his home, complaining of little more than headache. After ten days he returned to his work at the farm. Shortly after breakfast on the first morning, he was found lying dead in the field where he had been sent to gather potatoes. Necropsy revealed a trilobed saccular aneurysm, which had recently ruptured, situated at the junction of the left vertebral artery with the basilar, causing the vessel to be pulled over to the left but giving rise to no displacement of brain substance. The sac contained three chambers, the largest and most stoutly constructed being the original one connected with the lumen of the vertebral artery, while the two smaller divisions arose in succession from this. The whole sac measured 1.9 cm. in length by 1.1 cm. in breadth. Escaped blood had penetrated over most of the base of the brain into all the ventricles and down the whole length of the spinal cord.

Large Cardiac Aneurysm.—The exceptional size of the aneurysm was notable in the case cited by Shennan and Niven. On removing the anterior wall of the heart, a large pouching dilatation of the left ventricle was found, consisting mainly of the anterior and outer walls of that cavity. The left ventricle measured internally, from the lower attachments of the semilunar cusps to the pocket mentioned, 16 cm., and from the same point to the most projecting part of the aneurysm in the long axis of the ventricle, 16 cm. Internally, the greatest transverse measurement of the aneurysm was also 16 cm. In depth (width) the aneurysm varied from 5 to 9.5 cm. The circumference of the aperture of the mouth of the aneurysm, that is, the line demarcating it from the left ventricle measured 28.5 cm. The cause of the aneurysm was, without doubt, endarteritis of the anterior descending branch of the left coronary artery.

Carcinoma of Jejunum.—Flatulence and feeling of distention in the abdomen, of two weeks' duration, and intermittent abdominal pain without relation to food, which had been present for two months, were the chief symptoms in Lynch's case. Clinical examination showed a greatly distended stomach lying in the pelvis and resulted in a diagnosis of pyloric stenosis. At necropsy it was found that, 12 inches from the duodenojejunal flexure, there was a circular stricture of the intestine. The stricture was hard, extended through all coats and almost completely surrounded the bowel. The microscopic diagnosis was columnar cell carcinoma (adenocarcinoma) of the jejunum with stenosis and intestinal obstruction.

Lancet, London

1: 803-852 (April 18) 1925

*Rôle of Fats in Vital Phenomena. J. B. Leathes.—p. 803.
Arthritis in Childhood. F. J. Poynton.—p. 807.
*Year's Experience of Insulin. J. K. Rennie.—p. 811.
Operative Treatment of Cleft-Palate; Results in 125 Cases. H. H. Rayner.—p. 816.
Cleft-Palate. O. L. Addison.—p. 818.

Rôle of Fats in Vital Phenomena.—Leathes reviews current conceptions as to the relation between the fatty and other constituents of cells in the structure of their protoplasm.

Experience with Insulin.—Rennie reviews the results of the treatment of thirty-three diabetic patients with insulin. Four died. The remaining twenty-nine without exception showed improvement under insulin. Thirst and polyuria disappeared with varying rapidity in all cases, and in all the mental outlook was very greatly improved. Pruritus was rarely troublesome. One case of toxic amblyopia benefited very greatly while on insulin. In two cases the knee jerks, absent on admission, returned after a period of treatment.

Medical Journal of Australia, Sydney

1: 303-330 (March 28) 1925

Industrial Medical Service. D. G. Robertson.—p. 303.
*Interpretation of Reports on Opaque Meal Examinations. P. Parkinson.—p. 309.
*Hookworm Disease and General Practitioner. H. R. Pearson.—p. 314
Ununited Fracture of Neck of Femur Treated by Autogenous Bone Graft. A. V. Meehan.—p. 315.
Lesions of Bone. A. T. Nisbet.—p. 316.

Cooperation Between Practitioner and Roentgenologist.—Parkinson pleads for more effort on the part of practitioners to let the roentgenologist know the subsequent history of patients and the results of treatment. Such information would be invaluable in contributing to the roentgenologist's knowledge, adding to his experience and increasing his efficiency.

Diagnosis of Hookworm Infestation.—Pearson says that the Willis salt floatation method affords to every practitioner a simple, rapid and completely reliable method of securing positive diagnosis in any case of hookworm infestation. All that is needed is a small specimen of bowel motion (from 1 to 3 gm.) a small tin container, a saturated solution of common salt, a glass slide, a microscope and a few minutes in which to complete the examination. The small fecal mass is placed in the tin and thoroughly mixed with saline solution and is well stirred with a wooden tooth pick. The tin is then filled with saline solution, covered with the clear greaseproof slide and allowed to stand for five or ten minutes. A shorter time will suffice. The glass slide is removed, turned over and examined under a low power of the microscope (half inch objective and number five eye piece). Ova are readily detected floating on the saline solution on the top surface of the slide.

Archives des Maladies de l'Appareil Digestif, Paris

15: 97-200 (Feb.) 1925

Fatty Degeneration of Gastric Mucosa. G. Lion and Le Blaye.—p. 97.
Acid-Base Balance of the Organism. R. Goiffon.—p. 118.
Nontraumatic Diaphragmatic Hernia of the Stomach. E. Antoine and A. Bisson.—p. 147.

Bruxelles-Médical, Brussels

5: 795-828 (April 12) 1925

*Lesions of Myocardium in Tachycardia. V. Gallemaerts.—p. 795.
Orthopedics in 1924. P. Lorthioir.—p. 802.

Organic Lesions in Paroxysmal Tachycardia.—Electrocardiograms made in the intervals between attacks in seventy-six patients with paroxysmal tachycardia showed co-existing lesions of the myocardium in 71 per cent. The extrasystole and the disordered systoles originate in the same heterotopic center; thus the paroxysms in tachycardia seem to present an uninterrupted series of extrasystoles. Gallemaerts also points out the analogy between auricular and ventricular paroxysmal tachycardia.

Bulletin de l'Académie de Médecine, Paris

93: 349-368 (March 31) 1925

Malaria Treatment of General Paralysis. G. Marinesco.—p. 358.
*Preventive Serotherapy in Mumps. de Lavergne and Florentin.—p. 362.
*Myeloid Leukemia after Irradiation. P. Merklen et al.—p. 364.

Convalescents' Serum in Prevention of Orchitis in Mumps.—De Lavergne and Florentin treated 113 cases of mumps with convalescents' serum. Orchitis occurred in five instances, and a meningeal reaction in two, while among 107 control mumps patients orchitis was manifest in twenty-five and meningeal reactions in nine cases. The orchitis in five patients treated may be ascribed to an insufficient dose of the serum (10 or 15 c.c.). None of the twenty-eight injected subcutaneously with 20 c.c. (15 and 5 c.c.) developed orchitis. The serum used was taken from the fifteenth to the twenty-fifth day in cases of mumps free from complications, and at the time of general recovery in cases with orchitis.

Myeloid Leukemia Traceable to Irradiation?—Merklen, Wolf and Néel observed the case in a woman, aged 62. She had been submitted eight years before to roentgen-ray treatment for fibromyoma of the uterus. It was one of the first cases in which a prolonged and intensive dose of roentgen rays had been tried (seven hours of irradiation at one sitting).

93: 369-382 (April 7) 1925

*Convalescents' Serum in Mumps. Teissier.—p. 369.
The Geneva Conference on Narcotics. E. Perrot.—p. 375.
Forms of Diverticula in Esophagus. J. Guisez.—p. 378.
*Effect of Heat and Cold on Cholesterolemia. Parturier.—p. 381.

Prophylactic Value of Convalescents' Serum in Mumps.—The specific serotherapy was tried in an orphan asylum where thirty-seven girls had developed mumps. None of the twenty-two other girls, from 6 to 18 years old, injected with 10 or 20 c.c. of the serum contracted the disease. (See abstract below.)

Influence of Environment on Cholesterolemia.—Parturier's conclusion from experiments on guinea-pigs is that heat increases by 48 per cent. the amount of cholesterol in the blood. Cold reduces the rate in the same proportion. In air rich in oxygen, the action of heat was checked in 75 per cent. of the tests.

Bulletin Médical, Paris

39: 313-340 (March 21) 1925

*Cholecystography; E. A. Graham's Test. Gosset and Lœwy.—p. 319.
The Argyll Robertson Sign. A. Favory.—p. 324.

Cholecystography.—Gosset and Lœwy applied the Graham test in eighteen cases, followed by operation in thirteen. They found it a decided aid in the decision for an operation and the choice of the incision. One case confirmed that damage of the liver interferes with the elimination of the drug.

39: 343-370 (March 28) 1925

*Epidemiology and Prophylaxis of Mumps. P. Teissier.—p. 349.
Local Immunity. E. Rivalier.—p. 354.
Immunity in Syphilis. F. Gerbay.—p. 359.
*Treatment of Gonorrheal Urethritis. Philippeau.—p. 362.

Epidemiology and Prophylaxis of Contagious Parotitis.—Teissier used serum from adults convalescing from mumps in prophylaxis of orchitis. Of the 172 patients treated, 8.13 per cent. developed orchitis; of the 174 controls, 23.29 per cent. Of thirty-two patients injected with 20 c.c. of convalescents' serum, 12.5 per cent. had orchitis; of the thirty with a dose of 40 c.c., 6.6 per cent. The procedure is harmless and seems to afford definite protection. Favorable results were also obtained by the use of convalescents' serum in prophylaxis of the disease.

Vaccination Treatment of Gonorrheal Urethritis.—Philippeau reports good results from the intra-urethral injection of gonococcus vaccine.

39: 373-400 (April 4) 1925

The Ear in the Aged. P. Aubriot.—p. 379.
*Local Gangrene from Epinephrin Injections. Guillaume.—p. 382.

Local Gangrene from Epinephrin Injection.—Guillaume says that this occurs, especially in the fingers, after operations under local anesthesia with epinephrin, and after therapeutic subcutaneous injections of physiologic saline with epinephrin. The ischemia caused by the epinephrin may result in a more or less extensive necrosis of the tissues. In prophylaxis, he advises against injecting epinephrin into poorly vascularized tissues, such as the skin and cellular tissue, or wherever the local circulation is below par. He advocates the omission of epinephrin in solutions for local anesthesia. If given with physiologic solution, he makes the simultaneous injection of the physiologic solution into the cellular tissue and of the epinephrin, at some distance, into muscle. Superheated air treatment is recommended to promote the circulation in the gangrene condition; local ultraviolet irradiation may be useful.

Bulletins de la Société Médicale des Hôpitaux, Paris

49: 479-533 (March 27) 1925

Roentgenograms in Encysted Pleurisy. L. Babonneix et al.—p. 479.
*Syphilitic Arteritis. M. Labbé and L. Denoyelle.—p. 482.
*Skin Tests in Scarlet Fever. C. Zoeller.—p. 485.
*Chloroform in Tetanus Serotherapy. H. Dufour and Duhamel.—p. 491.
*Streptococcus Filtrate in Endocarditis. Marchal and Jaubert.—p. 495.
*Localized Fibrous Osteitis. A. Léri and A. Linossier.—p. 504.
Carotid Pulse in Aortic Insufficiency. A. Moukhtar.—p. 508.
*Osteomalacia in Girl. C. I. Urechia and I. Bodea.—p. 511.
Icterohemorrhagic Spirochetosis. De Lavergne and Perrier.—p. 513.
Meningo-Encephalitis with Jacksonian Spasms. Vialard et al.—p. 517.
Recovery from Tuberculous Meningitis. Vialard and Darleguy.—p. 522.
Bronchiectasis After Gangrene in Lung. Kindberg and Cottenot.—p. 525.
Pernicious Anemia Due to Radium. M. Brulé and R. Boulin.—p. 528.

Arteritis Simulating Raynaud's Disease—Labbé and Denoyelle observed a patient, aged 43, with arteritis in each limb, and a positive Wassermann reaction. The attacks resembled those in Raynaud's syndrome. No calcification was revealed by roentgenograms, and the cholesterol in the blood was within normal range. Combined arsphenamin and mercury treatment was followed by a remarkably prompt improvement.

Comparative Value of Skin Tests in Scarlet Fever.—Zoeller tried Caronia's filtrate of diplococcus cultures in fifty-six persons. A positive reaction appeared in 28 per cent. The reaction was less pronounced than the Schick or anatoxin reaction, or the Dick test. The Caronia reaction agreed with the Dick test in thirty-seven cases and disagreed in nineteen of the total fifty-six subjects. Two in the latter group were one positive and one weakly positive Caronia reaction among six convalescents from scarlet fever. Zoeller never saw an extinction phenomenon with the serum of subjects with a positive Dick test. Among the serums from subjects with negative Dick tests, four failed to produce the phenomenon. This can be explained by a difference in the antitoxic value of the serums. A negative Dick test, and especially strong neutralizing power of the serum at the beginning of an infectious disease, and a positive Dick test during and after its course testify against scarlet fever. He also made investigations on the Italian work. He found the same corpuscles in blood cultures from healthy subjects as he confirms in scarlet fever. Yet he never obtained a sufficient amount of the alleged cocci of scarlet fever to make agglutination and complement fixation tests.

Effect of Chloroform on Serotherapy in Tetanus.—Intraspinal injection of antitetanus serum, under chloroform,

resulted in a rapid recovery from the tetanus which had reached a very grave stage in the young man. It is assumed that the nervous tissue, submitted to the influence of chloroform, responds in an unusual way to the antibodies of the antiserum. The chloroform anesthesia had been induced to mitigate the opisthotonos to permit the intraspinal injection.

Inefficiency of Autofiltrate in a Case of Malignant Endocarditis.—Marchal and Jaubert tried intravenous injection of the filtrate from an autogenous culture in a case of streptococcus endocarditis, with a slow course, in a man, aged 48. No benefit was observed.

Recklinghausen's Disease Restricted to the Skull.—The lesion in Léri and Linossier's case was situated above the left orbit. Although the Wassermann test was negative, and no specific signs existed, the girl, aged 19, was given ten injections of bismuth. In a month the tumor had been reduced by a half, and the associated disturbances had disappeared. The success of specific treatment confirmed that congenital syphilis had been responsible.

Osteomalacia in a Girl Aged 17.—The disease started at the age of 10. Vagotonia was manifest. While organotherapy proved to be ineffective, administration of phosphorus induced a marked amelioration.

Comptes Rendus de la Société de Biologie, Paris

92: 845-932 (March 27) 1925. Partial Index

*Ureter Calculus in a Fish. R. Legendre.—p. 847.
*Enamel and Dentin. E. Retterer.—p. 848.
*Abnormal Location of Hemiazygos Vein. J. Vilde.—p. 891.
Methods for Determination of *p*H in Blood. Morera and Savino.—p. 893.
*Effect of Insulin on Collodion. Pico and Negrete.—p. 905.
Paralysis from Curare and Strychnin. Rebello and Fontès.—p. 912.
*Vagotonia and Resistance to Poisons. A. de Carvalho.—p. 918.

Calculus in Ureter of Dolphin.—Legendre reports a case of calculus in one ureter of a dolphin. The calculus measured 4.5 cm., weighed 41 gm., and responded to tests for uric acid and calcium phosphate.

Dentin and Enamel.—Retterer's study has confirmed that dentin and enamel have a common protoplasmic origin. Transformation of the dentin into enamel occurs before eruption, under the influence of compression exerted by the sac and by the gum.

Unusual Situation of Vein May Be Hereditary Phenomenon.—Vilde found in a female cadaver the hemiazygos vein located in front of the aorta. Referring to analogous findings in certain animals, he assumes that the phenomenon may be familial and hereditary.

Action of Insulin on Dialysis of Glucose.—Pico and Negrete tested the diffusibility of glucose through collodion in the presence of insulin and without it. With insulin, the concentration of glucose in the dialysates was higher after an hour.

Vagotonic Condition and Resistance to Poisons.—De Carvalho experimented on mice and on dogs. Hypovagotonia, induced by atropin, neither prevented nor checked the phenomena from potassium cyanid, when the latter was given afterward. Hypervagotonia from pilocarpin, administered before or simultaneously with the cyanid, lowered the resistance of the organism to the poison. Pilocarpin, given after the cyanid, seemed to exaggerate the toxic phenomena.

92: 933-1012 (April 3) 1925. Partial Index

*Complement in Smallpox and Alastrim. A. Netter and Urbain.—p. 952.
*Neutralization of Eclampsia Serum. Lévy-Solal et al.—p. 957.
*Quinin for Malaria Carriers. H. Foley and M. Brouard.—p. 958.
*Bloodletting with Return of Corpuscles. Gilbert and Tzanck.—p. 960.
Cultivation of Kidney Tissue in Vitro. A. Policard.—p. 974.
*Susceptibility to Dysentery. H. Brokman and F. Przesmycki.—p. 989.
*Vitamin B and the Metabolism. C. Funk et al.—p. 997.
*Mechanism of Arterial Hypertension. B. Gutowski.—p. 1000.
Influence of Brain Hemispheres on Each Other. J. Wysocki and L. Zbyszewski.—p. 1009.

Deviation of Complement in Smallpox and Alastrim.—Complement fixation tests in nineteen subjects with alastrim and in six with smallpox convinced Netter and Urbain that the causal factor is identical in both diseases.

Immunization Against Eclampsia Serum in Guinea-Pigs.—Lévy-Solal, Tzanck and Dalsace relate that desensitization of guinea-pigs with horse serum rendered them immune to intracardiac injection of eclampsia serum.

Preventive Action of Quinin in Latent Malaria.—Seventy children in Algeria, aged from 1 to 15 years, all carriers of plasmodia, were given daily, for six months, from 0.1 to 0.4 gm. of quinin. The results were a reduction of the parasite index from 53 to 11 per cent. While *Plasmodium praecox* disappeared completely, *Plasmodium vivax* persisted in a few children.

Technic for Bloodletting with Restoration of the Blood Corpuscles Withdrawn.—Gilbert and Tzanck give an illustrated description of their technic for bloodletting, immediately followed by reinjection of the subject's own blood corpuscles, after they have been centrifugated and washed in an isotonic solution.

Susceptibility to Dysentery.—Brokman and Przesmycki injected intravenously in mice, dysentery toxin mixed with serum of persons with a positive or with a negative reaction to dysentery. The experiments proved that the process of immunization, similar to that in diphtheria, involves the property of the organism to produce antibodies, neutralizing the toxin.

Rôle of Vitamin B in Protein and Carbohydrate Metabolism.—Funk, Collazo and Kaczmarek reiterate that with the same quantity of vitamin B an animal utilizes more protein-rich food than starchy food.

Factors in Arterial Hypertension.—Gutowski summarizes his observations on eight dogs and six cats with a severed spinal cord, tested by excitation of the vagus. The first phase of the resulting arterial hypertension, according to Tigerstedt's view, seemed to depend on the exaggerated output of blood expelled by the heart. The second phase, he says, is connected with an increase of epinephrin in the blood, and this requires normal functioning of the suprarenals and of the splanchnic nerves.

Paris Médical

55: 297-328 (April 4) 1925

Pathology of Digestive Tract in 1925. Carnot and Gaehlinger.—p. 297.
Benign Tumors of the Stomach. P. Lecène.—p. 313.
*Water Deficiency in Stenosis. Surmont and Tiprez.—p. 317.
Infection in Gastric and Duodenal Ulcers. Duval and Moutier.—p. 322.
Antiperistalsis in Large Intestine in Man. P. Blamoutier.—p. 325.
Medical Salon of 1925. See News Department, p. 1432.

Glucose Solution in Stenosis in Digestive Tract.—Surmont and Tiprez used drip enemas of a 4.7 per cent. (isotonic) solution of glucose in patients with stenosis of pylorus or cardia, suffering from lack of water. A liter of the solution was injected twice a day in from forty to ninety minutes; it was retained and perfectly tolerated. The fluid seemed to be rapidly absorbed, since the number of erythrocytes and the viscosity of the blood decreased immediately after the enema. The solution may be introduced before an operation, in place of the usual infusion of physiologic sodium chlorid solution.

Presse Médicale, Paris

33: 417-432 (April 1) 1925

Plastic Surgery of Knee Joint. E. Desmarest.—p. 417.
*Influence of Food on Gastric Secretion. Léon-Meunier.—p. 420.

Action of Ingested Substances on Gastric Secretion.—Léon-Meunier says that the first stage in gastric functioning is the psychic secretion, in which the organ of taste takes part. The second stage is the intragastric secretion, resulting from contact of the food with the stomach mucosa. This secretion, contrary to Pawlow's theory, does not depend on the kind of food. His experiments showed the secretion to be of osmotic nature, connected with the function of the soluble elements in the food. Proteins exert a strong excitation of the intragastric secretion; a moderate excitation is induced by starchy substances. His research confirms that fats check gastric secretion. The findings may direct the diet. Feeding through a tube chopped meat that has had the salts and extractives boiled out of it, supplies nourishment without any psychic or intragastric secretion, and thus might reduce gastric secretion to zero.

33: 433-448 (April 4) 1925

Insufficiency of the Left Ventricle. C. Laubry et al.—p. 433.
*Gastric Eosinophilia in Achylia. C. Bonorino Udaondo.—p. 437.

Gastric Eosinophilia in Differentiation of Achylia.—Bonorino Udaondo reports six new cases of gastric achylia of functional nature. In none of the patients did eosinophilia appear. These cases as well as previous observations confirm the assumption that eosinophilia occurs only in organic achylia with a lesion of the gastric mucosa.

33: 449-464 (April 8) 1925

*Iodin in Treatment of Tuberculosis. de Jong and Christophe.—p. 449.
Scoliosis from Asymmetry of Vertebra. H. Judet.—p. 450.
Congenitally Abnormal Skins. Veyrières and Guibert.—p. 451.
Parathyroids in Goiter Surgery. R. Valkanyi.—p. 452.

Uncertain Value of Iodin in Pulmonary Tuberculosis.—De Jong and Christophe treated with iodin by mouth or intravenously, forty patients with chronic tuberculous lesions of the lungs. So far, the treatment has not exerted any noticeable effect.

33: 465-480 (April 11) 1925

*Sympathectomy in Gynecology. R. Leriche.—p. 465.
Phrenicotomy in Pulmonary Tuberculosis. C. A. Perret et al.—p. 466.
Transportation of the Wounded. A. Vincent.—p. 475.

Favorable Results from Periarterial Sympathectomy on the Hypogastric and Ovarian Arteries.—Leriche has operated on twelve patients for metrorrhagia or dysmenorrhea of uncertain nature, amenorrhea, vulvar kraurosis or pruritus, or severe pelvic pains after radium treatment of the uterine cervix. The rapid and persistent recovery following the intervention testified to its usefulness in genital dystrophies or ovarian insufficiency. The results already realized, he says, justify application of this treatment to a whole set of syndromes hitherto refractory to all measures. This neurotomy on the sympathetic may prevent many useless or even aggravating operations on the ovaries.

Revue Française d'Endocrinologie, Paris

2: 381-476 (Dec.) 1924

Intracerebral Elimination of Pituitary Colloid. R. Collin.—p. 381.
*"Endocrine Fever." F. Arloing.—p. 403.
*Climacteric Hypertension. G. Marañon.—p. 408.
The Internal Renal Secretion. G. Richard and J. Roesch.—p. 423.

"Endocrine Fever."—Arloing observed variations in temperature, apparently of endocrine origin, in a woman, aged 40, with a history of thyroid disturbance. The temperature rose abruptly by nearly or a full centigrade degree in fifteen to twenty minutes, on change from the reclining to the erect position. Nearly as high a rise was noted before the menses. Under hydrotherapy with organotherapy for a year, the temperature curve gradually returned to normal, with a certain instability, which persisted for two and a half years. There did not seem to be any other signs of hyperthyroidism.

Climacteric Hypertension.—Marañon says that during the menopause more than half the patients present a more or less marked rise of systolic and diastolic pressure. Sometimes the hypertension coincides with headache, dizziness, palpitations particularly painful at night, and tinnitus, usually with other symptoms. If this hypertension in the climacterium is overcome, certain disturbances are alleviated and certain dangers removed. Ovarian organotherapy is indicated, supplemented by dietetic treatment, hydrotherapy and hygiene.

Revue Franç. de Gynécologie et d'Obstét., Paris

20: 185-200 (March 25) 1925

*Lumbar Puncture in Fetus in Breech Extraction. R. Costa.—p. 185.
Double Bicornate Uterus with Double Cervix. R. H. Kummer.—p. 190.

Lumbar Puncture in Living Child in Breech Presentation.—Costa used the method in seven cases of insufficient dilatation of the cervix and in three cases with narrow pelvis. All the infants were born alive, and only two of them could not be revived. The results of the puncture consisted in a reduction of the biparietal diameter, in decreased danger to the tentorium cerebelli, and in reduction of the pressure on the centers of respiration and heart functioning. Establishment of respiration in the new-born child appeared to be easier with this method.

Scalpel, Brussels

78: 341-360 (April 11) 1925

*Gastric Hemorrhage from Cholecystitis. G. Coryn.—p. 341.
Rupture of Fallopian Tube. O. Dauwe.—p. 343.
Mediastinum Hernia in Artificial Pneumothorax. Olbrechts.—p. 347.

Hemorrhage from Stomach Due to Cholecystitis.—Describing this case in a woman, aged 42, and comparing it with others in his experience, Coryn emphasizes that an apparently benign lesion of the gallbladder may induce grave hematemesis without any ulceration in the stomach. The case also teaches that when a gallbladder casts a shadow in roentgenography, it is unquestionably diseased.

Schweizer Archiv f. Neurol. u. Psychiatrie, Zurich

15: 163-330, 1924

Amnesia-Aphasia. K. Goldstein.—p. 163.
Experimental Herpes Infection. P. Bastai and Busacca.—p. 176. Cont'd.
Anatomy and Physiology of Reflexes. Minkowski.—p. 239. Cont'd.
Relation Between Psychic and Vegetative Functions. Hess.—p. 260.
Present Status of Clinical Reflexology. Brunschweiler.—p. 278.

Schweizerische medizinische Wochenschrift, Basel

55: 289-312 (April 2) 1925

Occupational Dermatoses. M. Winkler.—p. 289. Cont'd.
*Optic Registration of the Pulse. W. Baertschi.—p. 296.
*Rupture of Achilles' Tendon. E. Baumann.—p. 300.

Optic Registration of the Pulse.—Baertschi substitutes a mirror for the registering lever of Münzer's double recording drum.

Rupture of Achilles' Tendon.—Baumann observed two cases of rupture of Achilles' tendon, while the tendon of the plantar muscle remained intact—thus allowing a weak plantar flexion. This phenomenon may cause a grave blunder in diagnosis and prevent a suture in time.

Pediatria, Naples

33: 337-392 (April 1) 1925

*Vaccine Treatment of Scarlet Fever. G. Caronia.—p. 337.
*Mechanism of Action of Vaccine in Scarlet Fever. A. Ronchi et al.—p. 348.
*Thymus and Metabolism of Creatin. G. Macciotta.—p. 360.
Identity of Exfoliative Dermatitis and Erythrodermia. Sorgente.—p. 372.
Lymphogranuloma with Splenomegaly. E. Mensi.—p. 378.
Infantile Leishmaniasis. M. Mallardi.—p. 383.

Vaccine Treatment of Scarlet Fever.—Caronia added 10 c.c. of convalescents' serum to 100 c.c. of the Italian scarlet fever culture, incubated it for one day, then added again 10 c.c. of convalescents' serum, and after a new incubation added phenol as a preservative. He injected intravenously 0.5 c.c. of this mixture in scarlet fever patients and repeated the injection in some of them on the third day. He concludes that it shortened and mitigated the course of the disease. A control with noninoculated culture mediums is not mentioned.

Mechanism of Action of Vaccine Treatment of Scarlet Fever.—Ronchi, Sabatini and Cartia publish detailed reports on the blood changes following the injection of the preparation described in the foregoing abstract. Serial blood counts were made for several hours after the injection. They conclude that the initial symptoms are due to the nonspecific action of the fluid. They suppose that the rest is due to its specific constituent.

Thymus and Metabolism of Creatin.—Macciotta extirpated the thymus in rabbits about one month old. After an initial rise, the creatin disappeared from the urine, while creatinin remained almost as high as before. The titration alkalinity of the blood increased in the first period and decreased in the second. He thinks that the influence of the thymus on the creatin metabolism is connected with an antagonistic action of the suprarenals and gonads.

Policlinico, Rome

32: 479-513 (April 6) 1925

*Sterilizing Treatment in Recent Syphilis. Philippson.—p. 479.
Rare Form of Littré's Hernia. S. Marinacci.—p. 487.
Plastic Linitis of the Stomach. L. Tomasi.—p. 489.

Sterilizing Treatment in Recent Syphilis.—Philippson had success in the majority of patients with recent syphilis using

neo-arsphenamin alone or combined with mercury treatment. The dose of 0.3-0.45 gm. should serve only to test the tolerance of the patient, and should be increased to 0.60, 0.75 and 0.90 gm. The intervals should be five to seven days. About 5 gm. should be introduced within forty days. The condition of the lymph nodes is a good criterion of the treatment. With signs of intolerance, the dose should be reduced but the intervals made shorter. The first course is decisive for the successful outcome. A second should follow in two months. He discusses the cause of a few failures, and reports the remote results (Wassermann test, healthy children, and reinfections).

Archiv für Kinderheilkunde, Stuttgart

75: 241-320 (March 20) 1925

Bismuth Treatment of Congenital Syphilis. Levy and Selter.—pp. 241, 281.
*Tetany in Infants. A. Bratusch-Marrain.—p. 255.
Prevention of Goiter in Children. Eckstein and Feldmann.—p. 263.
*Tuberculin in Treatment of Whooping Cough. C. Stuhl.—p. 277.
Cerebrospinal Fluid in Syphilitic Children. F. von Gutfeld and G. Meyer.—p. 302. Cont'd.
Chronic Osteomyelitis in Infants. J. Renz.—p. 308.

Pathogenesis and Treatment of Tetany in Infants.—Bratusch-Marrain found the exclusion of milk from the diet effective in almost all cases, the spasms often disappearing in a few hours. Addition of sugar to cow's milk mixture (Wernstedt) produced a slight decrease in the electric irritability, attributed to acids arising from the sugar fermentation. The manifestations of tetanic symptoms coincided with retention of water, subsiding on relief of the symptoms and probably due to alkalosis or acidosis. If the discontinuance of the milk does not suffice in treatment, he recommends ammonium chlorid, also calcium and cod liver oil, with phosphates.

Tuberculin in Treatment of Paroxysmal Stage in Whooping Cough.—Stuhl reports good results in the seventeen infants and young children treated. The first injection of 0.0001 mg. of old tuberculin was followed in three days by the second, the dose increased by half. He cautions against larger doses, and the use of high dilutions more than four weeks old. The paroxysms ceased after six to eight injections (about three weeks). Nervous children may have paroxysmal-like attacks during convalescence. The treatment was usually begun at the onset of the convulsive stage; difference of a week's time in beginning apparently did not affect the results.

Deutsche medizinische Wochenschrift, Berlin

51: 547-588 (April 3) 1925

High Frequency Currents. L. Mann.—p. 547.
*Exchanges of Fluids in Brain. R. Bieling and R. Weichbrodt.—p. 551.
Blood Diseases in Children. E. Stettner.—p. 554.
*Steinach's Operation. Schinz and Slotopolsky.—p. 557. Conc'n.
*Anatomy of Hering's Carotid Reflexes. L. Drüner.—p. 559.
Treatment of Lupus. Axmann.—p. 560.
*Constancy of p_H of Saliva. E. Popper and F. Haffner.—p. 561.
Autohemotherapy in Erysipeloid. W. Richter.—p. 652.
Portable Pneumothorax Apparatus. R. Kohler.—p. 563.
Sexual Life of Children. S. H. Falkenstein.—p. 565.
Menthol Cigarettes. A. Hartmann.—p. 565.
Medical Aspects of Sport. H. Rautmann.—p. 565.
*Virchow and Humoral Pathology. H. Freund.—p. 568.
Public Health Statistics of Sweden. E. Roesle.—p. 569.
Isolation of School Children with Venereal and Skin Diseases. M. Gumpert.—p. 571.
Tuberculosis Sanatoriums and Social Insurance. Reckzeh.—p. 572.

Exchanges Between Blood, Cerebrospinal Fluid and Brain.—Bieling and Weichbrodt found a noticeable transmission of antibodies from the blood into the cerebrospinal fluid during therapeutic recurrent fever. It is well known that the passage from the fluid to the blood seems to be much easier than the reverse; drugs, antiserums and microbes pass into the blood rapidly. The opposite barrier is not absolute; it depends on the concentration of the substance in the blood. Bromin appears in a higher concentration than iodin in the cerebrospinal fluid, because its blood level can be raised higher and because its elimination by the kidneys is slower.

Steinach's Operation.—Schinz and Slotopolsky conclude that the stimulating effect of ligation of the vas deferens is due to resorption of destroyed seminal epithelium—not to an increased functioning of a "puberty gland." The operation is indicated only for sterilization, and as a last resort in premature organic impotency.

Anatomy of Hering's Carotid Reflexes.—Drüner deals with the anatomic bases of Hering's carotid compression reflexes ("vagus pressure"). He finds that the carotid gland is an organ of special sense—serving chiefly as the source of these blood pressure reflexes.

Constancy of p_H of Saliva.—Popper and Haffner made electrometric determinations of the hydrogen ion concentration of the saliva. It varied in healthy individuals between p_H 6.7 and 7.52, but was fairly constant in the same subject, provided the condition of the teeth remained the same.

Virchow and Humoral Pathology.—Freund shows that Virchow's theory was not one-sided: he regarded a disturbance of diffusion of substances between the blood and tissues as the pathogenetic basis. The purely humoral pathology is dead.

Klinische Wochenschrift, Berlin

4: 625-680 (April 2) 1925

Experimental Zoology and Pathology. G. Herzog.—p. 625.
*Rays and Proteins in Transmineralization. C. Kroetz.—p. 631.
*Anatomy of Yellow Fever. W. H. Hoffmann.—p. 632.
*Immune Treatment of Warts and Condylomas. H. Biberstein.—p. 638.
*Gallbladder and Pituitary. W. Schöndube.—p. 640.
*Pathogenesis of Peptic Ulcer. J. R. F. Rassers.—p. 644.
*Lipoids in Atherosclerotic Vessels. H. Kutschera-Aichbergen.—p. 645.
*Rheumatic Tendovaginitis. A. Roseno.—p. 646.
Bismuth Treatment of Syphilis. Steegmüller.—p. 650.
Microscopic Diagnosis of Tumors of Pleura. E. Bock.—p. 651.
*Oxidation of Melanin in Sections. M. Schmidtmann.—p. 652.
*Action of Potassium on Blood Sugar. E. Kylin and A. Engel.—p. 653.
Clinical Significance of Enlarged Heart. A. Schott.—p. 653.
Fatty Infiltration. P. Huebschmann.—p. 658.
*Technic of Roentgen Enema. E. Reiser.—p. 678.

Rays and Protein in Transmineralization.—Kroetz points to the changes of the mineral constituents and proteins of the serum after irradiation and injections of foreign and own proteins.

Anatomy of Yellow Fever.—Hoffmann differentiates yellow fever by the constant presence of peculiar lime casts in the kidneys and by the graver injury to the liver and kidney in comparison with Weil's disease. He found besides this regularly in yellow fever a marked phagocytosis of erythrocytes in the spleen, liver and lymph nodes, Zenker's degeneration of the heart and striated muscles, and a swelling of the follicles and Peyer's patches in the small intestine. The same changes were found in guinea-pigs inoculated with *Leptospira icteroides.*

Immune Treatment of Warts and Condylomas.—Biberstein reports recovery of 75 per cent. of his 139 patients with warts and condylomas. He made ten or more injections of an autolysate from the warts.

Gallbladder and Pituitary.—Schöndube reports on the results of the pituitary action on the gallbladder found by Kalk and himself. Subcutaneous injection of an extract from the posterior lobe of the pituitary provokes in healthy subjects in twenty-five or thirty minutes a flow of pure gallbladder bile. Its concentration is higher than with any other (magnesium sulphate or peptone) method: in healthy subjects more than 200 Hijmans van den Bergh's units. The gallbladder concentrates the liver bile up to ninety-fold. In many cholecystitis patients the concentration is less and the time of appearance of the dark bile is delayed or shortened (excitability). In many of them the "pituitary reflex" is negative. He attributes the contraction to a mild stimulation of the vagus.

Pathogenesis of Peptic Ulcer.—Rassers' starting point was Bechhold's theory of the secretion of acid. This postulates splitting of the sodium chlorid of the stomach contents by adsorption of the sodium ion. Rassers believes that this ion which remains in the gastric wall protects it against the stomach contents. The intestine with its alkaline secretion has an opposite mechanism for protection. He fed four dogs for two weeks on a diet lacking salt and vitamins, and then introduced acid and pepsin through a stomach tube, repeating this from twelve to twenty-seven times. All four dogs developed ulcers of the stomach, and two of them ulcers of the duodenum in addition. Two controls fed equally but

without the acid and pepsin, and without introduction of the tube had no changes in the stomach.

Lipoids in Atherosclerotic Vessels.—Kutschera-Aichbergen compared the lipoids in stained frozen sections and in extracts from normal and atherosclerotic arteries. He found that only the majority of acetone-soluble lipoids can be stained in the sections. The other lipoids which are insoluble in acetone (such as lecithins and cerebrosids) take the stain in vitro after extraction but never in the sections. Yet their amount is considerably increased in atheromatous vessels.

Rheumatic Tendovaginitis.—Roseno describes two cases of acute multiple tendovaginitis. Because of the grave symptoms, a diagnosis of purulent inflammation was made in the first case. An incision revealed only a small amount of serous fluid. Salicylates cured the condition promptly.

Oxidation of Melanin in Sections.—Schmidtmann used potassium persulphate for oxidation of tissues. The resulting pigment resembled melanin. Human serum usually does not stain brown with the reagent, but serums from some domestic animals do.

Action of Potassium on Blood Sugar.—Kylin and Engel injected 0.15 gm. of potassium chlorid intravenously in healthy subjects. The blood sugar decreased in all of them within fifteen minutes and returned to normal in an hour.

Technic of Roentgen Enema.—Reiser recommends the prone position in roentgen-ray examination of the colon. It prevents an overfilling of the ampulla, but requires a control in the dorsal position.

Medizinische Klinik, Berlin

21: 493-528 (April 3) 1925

Hemoptysis in Tuberculosis. A. Walder.—p. 493.
*Smallpox, Chickenpox and Cowpox. R. Jaksch-Wartenhorst.—p. 497.
*Pernicious Anemia and Lymphogranulomatosis. O. Halíř.—p. 498.
Insulin and the Practitioner. M. Kulik.—p. 500.
Syphilis of the Bladder. F. Moses.—p. 501.
*Foreign Body in the Lungs. A. Sindler and L. Weidenbach.—p. 503.
*Tenderness of Vertebrae in Mitral Disease. Loewenstein.—p. 505.
Autohemotherapy in Diabetes. C. Funck.—p. 506.
*Treatment of Oxyuriasis. R. Geinitz.—p. 507.
"Practical Consequences of Heredity." Aschner.—p. 508. Reply. Bauer.—p. 508.
Survey on Laryngology and Rhinology. Haenlein.—p. 514.
Examination in Pathologic Physiology. Marchand.—p. 525.
Furnishing Drugs to Social Insurance Beneficiaries. Reckzeh.—p. 525.

Smallpox, Chickenpox and Cowpox.—Jaksch-Wartenhorst disagrees most decidedly with Sahli's neo-unitarian views summarized in these columns, page 712, Feb. 28, 1925. His forty years of clinical experience and observation of several epidemics have convinced him that smallpox is etiologically absolutely different from chickenpox. Cowpox vaccination was always positive in nonvaccinated chickenpox patients, always negative in varioloid. The lightest cases may show a marked resemblance, but he never saw recurring crops of the exanthema with exacerbations of fever in varioloid. He believes that Sahli's alleged chickenpox cases were alastrim—a mild smallpox which, however, may turn dangerous (14.5 per cent. mortality in São Paulo). Strict vaccination and revaccination safely prevents smallpox, varioloid and alastrim.

Pernicious Anemia and Lymphogranulomatosis.—Halíř's patient was a young woman with clinical and hematologic signs of pernicious anemia after a pregnancy. The syndrome recurred in another pregnancy. Later on (about four years) the anemia was of a secondary type, and lymphogranulomatosis dominated the clinical picture.

Foreign Body in the Lungs.—Sindler and Weidenbach report the history of a boy, 5 years of age, who had a suffocative attack after extraction of a tooth. The dentist said that the tooth was out, and a physician treated the boy for pneumonia, which started three days later. The patient came to the clinic with an abscess in one lung eight weeks later, and roentgen-ray examination revealed a molar tooth lodged at the bifurcation. The boy died after the operation.

Tenderness of Vertebrae with Mitral Defect.—Loewenstein observed a tenderness of the first three or four thoracic vertebrae in mitral valve defects with failing compensation. The symptom was absent with aortic lesions. The whispering voice was also transmitted better in the area mentioned.

Treatment of Oxyuriasis.—Geinitz found Lorentz' treatment of oxyuriasis with cold washing of the anal region insufficient. He had satisfactory results by giving two raw carrots, eaten like raw fruit, or scraped, repeated the next day. This is an old household remedy in his region.

Münchener medizinische Wochenschrift, Munich

72: 545-584 (April 3) 1925

*Treatment of Acute Empyema. W. Graf.—p. 545.
*Action of Strontium. F. Salzmann and F. Haffner.—p. 550.
Insufflation of Fallopian Tubes. E. Koch.—p. 551.
Tuberculous Strictures of the Rectum. H. Jessen.—p. 553.
*Amputation of Leg. A. Lehrnbecher.—p. 554.
Spontaneous Gangrene of the Leg. E. Haller.—p. 556.
*Infections After Primary Suture. K. Laemmle.—p. 557.
*Tropical Comatose Malaria. H. Higier.—p. 559.
*Epidural Injections in Sciatica. H. Jordan.—p. 560.
Infiltration of Tissue by Injections of Own Blood. Ebers.—p. 565.
*Death by Electric Current. R. Weber.—p. 566.
Obstetrics from Medicolegal Standpoint. M. Hofmeier.—p. 566.
"Combined Treatment of Septicemia." P. Rosenstein.—p. 567.
*Diabetes Insipidus. F. Umber.—p. 569.
Sanatoriums and the Fight Against Tuberculosis. Blümel.—p. 570.

Treatment of Acute Empyema.—Graf publishes in detail the treatment he has been using the last year in acute purulent pleurisy. Because of the almost regular concomitant inflammation of the lung, every intervention which expands the lung forcibly should be avoided. Perthes' low pressure aspiration can be used only carefully, and in later stages. Sauerbruch's blowing up of the lungs by high pressure is a grave injury. Graf used Iselin's method of airtight drainage of the pleural cavity after resection of a rib. The drainage should take half a day, and the patient must not feel the slightest discomfort. The most important point is to avoid a pneumothorax. A bubble of air may prevent the all-important complete adherence of the visceral and costal pleura of the upper part of the lungs, which takes place in two days. After this, the lower portion of the exudate may be removed easily. Even in the second stage, lasting for five to seven days, any attempt to expand the lung should be avoided unless the lung is manifestly healthy. If the suppuration persists after a week of careful rinsing with antiseptic solutions—especially with a 2-5 per cent. surgical solution of chlorinated soda—the presence of a foreign body (necrotic tissue) or fistula is practically certain.

Action of Strontium.—Salzmann and Haffner found the contractions of the frog heart more pronounced, with less disturbances of rhythm, after strontium salts than after equimolecular concentrations of calcium. In great dilutions the effect was less—depending on the potassium content. Even in higher concentrations of strontium, the potassium effect is more distinct than with calcium.

Amputation of Leg.—Lehrnbecher discusses critically his own experience with low amputation of the leg after a shell wound. The long stump is an advantage if capable of supporting weight. It should rest on a rubber pad which is higher in the middle—not on a soft cushion. The state of mind is an essential element. Every surgeon remembers how calmly the soldiers took their grave wounds—some probably because they were glad to get out of the battle alive. Later, those who were treated in the military hospitals got along well. In the smaller charitable institutions the sympathy of the public was depressing, and the reeducation of the maimed was deficient unless the ambition and will were roused for rehabilitation.

Infections After Primary Suture.—Laemmle reports a disappearance of wound infections when instruments were boiled in a soda solution instead of being sterilized with hot air as previously.

Tropical Comatose Malaria.—Higier's patient had sudden signs of meningitis, after having had slight attacks of moderate fever for a few weeks. The cerebrospinal fluid was bloody and gave a positive Wassermann reaction. After three days of this condition and of 39 C. fever, a new spinal puncture was made. The fluid contained parasites of tropical malaria. The patient died fifteen hours after an injection of quinin. The malaria had not been recognized before in spite of examination of a blood slide.

Epidural Injections in Sciatica.—Jordan obtained permanent success in ten cases of sciatica while the treatment failed in two others. The epidural injection of 8-10 c.c. of a 40 per cent. solution of antipyrin, as recommended by Högler, produced no untoward effects.

Death by Electric Current.—Weber reports two instances of death following contact with an electric light bulb (220 volts).

Diabetes Insipidus.—Umber observed in some cases of diabetes insipidus, with normal or increased amount of chlorids in the blood, that injection of pituitary preparations had very little effect. The hypochloremic type responded well, and retained chlorids. He saw no influence from insulin in four cases.

Wiener Archiv für innere Medizin, Vienna

9: 393-540 (March 30) 1925

*Paravertebral Triangle of Dulness. D. Markó.—p. 393.
Duodenal Contents After Various Proteins. M. von Lemešić.—p. 401.
*Insulin and Gain in Weight. J. S. Lorant.—p. 409.
*Changes in Coronary Arteries. J. Kretz.—p. 419.
*Albumin in Urine During Function Tests. F. Lasch.—p. 437.
*Use of Hemograms. W. Freundlich.—p. 447.
*Acid Poisoning. L. Hess and J. Goldstein.—p. 461.
*Iodin Hyperthyroidism and Auricular Fibrillation. O. Roth.—p. 475.
*Quinin-Fast Lipase in Malaria. I. N. Dimitrijević.—p. 499.
Peripheral Leukocytes After Death. Donath and Perlstein.—p. 503.
*Kidney Function Test with Iodid and Thiosulphate. Nyiri.—p. 511.

Paravertebral Triangle of Dulness.—Markó concludes that Grocco's sign is merely an acoustic phenomenon due to a muting action by the exudate clinging to the spine, and thus muffling the sound. This explanation has already been given by F. Korányi, who described the sign in 1897 (before Grocco).

Insulin and Gain in Weight.—Lorant's study of two diabetes patients shows that the gain in weight after insulin is not due merely to a retention of water. It is associated with a positive balance of salts and nitrogen.

Changes in Coronary Arteries.—Kretz found little parallelism between the clinical history and the anatomic findings in 106 cadavers. He agrees with the authors who declare that frequently clinical symptoms are mistakenly attributed to sclerosis of the coronary arteries. Six out of sixteen cases of extreme sclerosis and narrowing of the lumen had had no cardiac symptoms during life. Only four had a distinct insufficiency of the heart. He points out that the normal lumen of the coronary arteries is comparatively small, and cites instances of thrombosis of both coronaries which did not cause marked disturbances. He believes that the heart muscle may receive part of its supply directly from the ventricles. He emphasizes that changes in the media in his cases were not postmortal as they were in others.

Albumin in Urine During Concentration and Dilution Test.—Lasch studied the changes of protein concentration in blood and urine during the diuresis and concentration test. He concludes that albuminuria is an active secretive function. Its quantitative changes during the test speak for a good function, its constancy for destruction of the convoluted tubules.

Use of Hemograms.—Freundlich made qualitative examinations of blood slides in fifty patients. The results were correct in 70 per cent. of the cases, unexplained in 22 per cent., and at variance with the clinical findings in 8 per cent. The method is of greater value for diagnosis than for prognosis.

Acid Poisoning.—Hess and Goldstein found necrotic foci and a lowered ability to accept trypan blue in the liver of rabbits poisoned with hydrochloric acid. They consider this alteration of the liver cells an important factor in the pathology of acidosis.

Iodin Hyperthyroidism and Auricular Fibrillation.—Roth observed auricular fibrillation in eleven goiter patients with symptoms of iodin hyperthyroidism. One of them recovered after thyroidectomy, two after the hyperthyroid symptoms had disappeared.

Quinin-Fast Lipase in Malaria.—Dimitrijević found a quinin-fast lipase in the serum of forty-two out of sixty-three patients with tertian malaria. In nine the reactions were not distinctly positive. He attributes the phenomenon to the affection of the liver, although there was no complete parallelism with the urobilinogen test. No atoxyl-fast lipase was present in these serums.

Kidney Function Test with Sodium Iodid and Thiosulphate.—Nyiri has advised a combined kidney function test, using a single intravenous injection of 1 gm. of sodium thiosulphate and 1 gm. of sodium iodid in 10 c.c. of water, and examining the elimination of these substances after two and three hours. He found besides this that the urine of two diabetic patients bound a considerable quantity of iodin even after being treated with charcoal.

Wiener klinische Wochenschrift, Vienna

38: 373-398 (April 2) 1925

*Carbohydrates in Plants and Animals. A. Gottschalk.—p. 373.
*Immunization with Atoxic Filtrates. R. Kraus and K. Imai.—p. 375.
Transposition of Vessels in a Monster. H. Mathis.—p. 378.
*Autogenous Vaccines in Colitis. K. v. Knorr.—p. 381.
Spontaneous Pneumothorax. A. Schick.—p. 383.
Microtest for Chlorids in Tissues. E. Urbach and P. Fantl.—p. 384.
Sanocrysin Treatment in Denmark. Poindecker.—p. 385. Conc'n.
Treatment of Edema. F. Brunn.—p. 387.
Diencephalon-Pituitary System and Vegetative Disturbances. A. Schiff.
Supplement.—pp. 1-23.

Cleavage of Carbohydrates in Plants and Animals.—Gottschalk reviews recent investigations which have demonstrated that the fermentative and oxidative cleavage of carbohydrates is identical in animals and plants. The formation of a hexose-diphosphoric acid ester by yeast and muscles is enhanced by the same coferment. The cleavage begins with the splitting into compounds containing three carbon atoms. Neuberg and his co-workers established acetaldehyd as an intermediary product in the oxidation of these compounds. Pyruvic acid may be its precursor. Insulin stimulates the formation of acetaldehyd in animal cells just as glycokinins increase it in both animal and vegetable. Besides this, it may perhaps act as coferment.

Immunization with Atoxic Filtrates.—Kraus and Imai endeavored to immunize rabbits with filtrates from young diphtheria and Shiga-Kruse cultures which were not yet toxic. They succeeded only with the dysentery germs. They discuss the possibility of practical use of the method instead of Löwenstein's toxoids made by means of formaldehyd from tetanus toxin, and Ramon's toxoid ("anatoxin") made by the same method from diphtheria toxin.

Autogenous Vaccines in Colitis.—Knorr treats colitis (including the mucomembranous form) with injections of a vaccine cultivated from the patient's stool.

Zeitschrift für Urologie, Leipzig

19: 161-240, 1925

Physiology and Pathology of Ureter. V. Blum.—p. 161.
Nonirritating Urinary Antiseptics. R. Oppenheimer.—p. 193.
Tuberculosis of Urinary Organs. E. Joseph.—p. 196.
Roentgen Diagnosis of Bladder Tumor. E. Bortini.—p. 202.
Varices in Bladder. A. Matusovszky.—p. 207.
Improved Cystoscope Holder. H. Vogel.—p. 212.

Zentralblatt für Chirurgie, Leipzig

52: 737-784 (April 4) 1925

*Gumma in the Thyroid. C. H. Lasch.—p. 738.
Diagnosis of Stones in Lower Ureter. R. Reinecke.—p. 740.
*Acute Serous Peritonitis. G. Gurewitsch.—p. 744.
Chyle Cyst with Serous Mesenteric Cyst. S. Sofoteroff.—p. 747.
*Nephropexy. E. Bundschuh.—p. 751.
Modification of Schmerz' Clamp Extension. R. Andler.—p. 754.
The Alcohol Denaturing Question. W. Haas.—p. 763.

Gumma in the Thyroid.—The difficulty in diagnosis and the local insufficiency of specific antisyphilitic treatment are illustrated in Lasch's case, in a girl, aged 18, with a solid tumor in the thyroid, enlarged lymph glands, positive Wassermann reaction, and a history of discharge from the knee diagnosed as tuberculosis, five years earlier. The histologic findings indicated gumma. Correct diagnosis without operation has been made in but few of the cases reported.

Acute Serous Peritonitis.—Gurewitsch believes that affections of the intestine may cause a sympathetic peritoneal infection, with clinical manifestations of acute appendicitis not verified by the pathologic anatomic findings. As in the

two cases described, these vary according to the character of the infection and the individual constitution.

Nephropexy.—In nephropexy according to Rehn, the kidney is suspended from the twelfth rib by a strong silk suture drawn through skin, muscle and the lower pole of the kidney. Bundschuh's modification substitutes for the silk an autoplastic strip of fascia lata. He finds this a simpler procedure than fixation with a pedunculated strip of fascia from the kidney capsule.

52: 785-848 (April 11) 1925

*Resection of Patella. Ludloff.—p. 786.
Technic for Removal of Coccyx. A. Peiser.—p. 789.
*Atony of Stomach After Billroth I. W. Roller.—p. 790.
Diet After Stomach Operations. A. Jarotzky.—p. 791.
Capillary Examination in Accident Surgery. Hoche and Pfab.—p. 794.
*Intracardiac Epinephrin Injection. A. Schapiro.—p. 798.
"Tannin for Disinfection of Hands." L. Nisniewitsch and T. Schiperowitsch.—p. 799.
Extension Apparatus. K. Spannaus.—p. 801.
Operative Treatment of Bone Fractures. L. Böhler.—p. 802.

Resection of Patella for Better Functioning in Knee Affections.—Ludloff resects the patella in certain forms of arthritis deformans; in cases of extensive friction of the cartilages; with cartilage tears on the posterior side of the patella, and as the final operation in recurrent and congenital dislocation of the patella. He describes this treatment applied to one knee in a case of bilateral congenital luxation of the patella in a woman, aged 40, with resulting normal movements. The patient now wants the operation on the other knee. Because of possible dislocation of the internal semilunar cartilage, he advises observation of the condition of the cartilage before and on opening the joint, and its extirpation if necessary.

Atony of the Stomach After Billroth I.—Roller reports a grave case in a young woman, appearing the second day, with vomiting of large quantities of bile daily. A second laparotomy two weeks after the first revealed extreme dilatation of the stomach, with permeable pylorus. Gastro-enterostomy a week later resulted in rapid recovery. He believes that further narrowing of the opening at the pylorus and the increasing dilatation of the stomach, due to the hypersecretion, pushed the transverse colon and loops of the small intestine downward, thus stretching the mesentery and causing arteriomesenteric occlusion. The gastro-enterostomy, emptying the stomach, corrected the condition at once.

Resuscitation by Intracardiac Injection of Epinephrin.—In Schapiro's patient, aged 75, complete collapse occurred after excision, under general anesthesia, of an extensive carbuncle on the neck. Camphor subcutaneously, strophanthin intravenously, were ineffective, also artificial respiration, etc. Then epinephrin was injected into the heart muscle, with restoration of the pulse in twenty seconds and return of the normal color of the skin and regular breathing. Complete recovery followed after a few days under heart stimulants. Injection of epinephrin directly into the heart muscle is advised in all cases of acute, particularly postoperative, arrest of the heart action.

Zentralblatt für Gynäkologie, Leipzig

49: 673-736 (March 28) 1925

Immunization Against Puerperal Infection. H. Biermer.—p. 674.
Pregnancy After Roentgen Irradiation of Ovaries. Meiner.—p. 682.
Lipoids of Corpus Luteum. E. Momigliano.—p. 684.
Hypertrophy of Uterine Mucosa and Glandular Endometritis. Lahm.—p. 689.
Intraspinal Anesthesia for Gynecologic Laparotomies. Krönig.—p. 696.
Technic for Blood Transfusion. G. H. Schneider.—p. 703.
Causes of Sterility. S. Weissenberg.—p. 706.
An Ovarian Pregnancy in Early Stage. A. Barna.—p. 718.

49: 737-784 (April 4) 1925

*Dietetic Prophylaxis of Eclampsia. W. Gessner.—p. 738.
Kielland Treatment of Prolapse of Female Genitals. Conrad.—p. 743.
Pernicious Aplastic Anemia of Pregnancy. F. Clauser.—p. 752.
*Pregnancy and Carcinoma. K. Sommer.—p. 758.
The Kielland Forceps. H. Saenger.—p. 762.
Extraperitoneal Vaginal "Small" Cesarean Section. Heinsius.—p. 763.
Extension of Puerperal Parametritis. N. Krupenikoff.—p. 765.

Dietetic Prophylaxis of Eclampsia.—Gessner sees the cause of eclampsia in sluggish metabolism as a consequence of the fatty, doughy habitus, and says that neither a qualitatively nor quantitatively regulated diet alone can prevent a single case of eclampsia if, at the same time, plenty of outdoor exercise is not taken.

Influence of Pregnancy on Cancer.—In Sommer's first case, an unsuspected epithelioma of the cervix in a woman, aged 38, was first revealed by a septic abortion. The cancer had not progressed and total extirpation resulted in a good recovery. In the second case, however, in a woman, aged 36, disturbances set in during the eighth month, with rapid aggravation and diagnosis of extensive cancer of the uterus. The operation revealed extensive infiltration of the parametrium with metastases in bladder and rectum. Penetration into the lymph and blood circulation in the hyperemic cervix tissue, he says, leads to rapid growth of the cancer, which explains the poor operative results in the second half of pregnancy.

Časopis lékařů českých, Prague

64: 521-560 (April 4) 1925

Tuberculosis and Pregnancy. V. Rubeška.—p. 521. Cont'n.
*Index of Efficiency of Blood Circulation. B. Prusík.—p. 525.
Insulin Treatment of Diabetic Coma. J. Cervenka.—p. 531. Conc'n.
*Differential Diagnosis of Flint's Symptom. Mentl.—p. 532. Conc'n.
American Methods of Estimation of Basal Metabolism. Mačela.—p. 538.
*Levaditi's Encephalitis Vaccine. K. Henner.—p. 543.

Index of Efficiency of Blood Circulation.—Prusík observed in the ten best runners of ski races an oscillation of the pulse pressure of 6.37 mm. of mercury before the races and 6.64 mm. after. In the ten that came in last in the race, the first average oscillation was 5.35, the second 4.50 mm. mercury. These figures were individually parallel to the difference between the systolic and diastolic pressure, and in inverse relation to the frequency of the pulse. He expresses the findings in an index, the numerator of which is the product of the differential pressure multiplied by the maximum oscillation in millimeters of mercury, and the denominator the pulse rate per minute. The index of the best runners varied between —7.42 and 3.55 (average 5.26) before the races; in the last ten (out of 129) runners it varied from 6 to 1.29 (average 2.83). After the races, the index was smaller: 3.94 for the first ten and 1.83 for the last, after a race of 18 km. Analogous results were obtained in the 50 km. race, except that the index after the race was about 40 per cent. lower. He recommends in pathologic cases to multiply the index by 75 per cent. of the diastolic pressure (taken at the time of maximal oscillations), and divide it by the body weight in kilograms. The determination of this index is simpler than any other dynamometric method for estimation of the efficiency of the circulation.

Differential Diagnosis of Flint's Symptom.—Mentl points to the importance of the correct diagnosis of Flint's sign as a guide to treatment. The presystolic murmur at the apex in cases of aortic insufficiency is always associated with a splitting of the second mitral sound if it is due to an organic lesion of the mitral valve. He never heard it with a mere Flint sign. The blood pressure and especially the roentgen examination furnish further diagnostic helps. A diastolic murmur may originate either in the mitral or in the pulmonary valve, instead of in the aorta, in cases of organic mitral stenosis. The differential diagnosis is the same.

Levaditi's Encephalitis Vaccine.—Henner tried Levaditi's living virus-vaccine in epidemic encephalitis. The first injection (intraspinal) is with 0.1-0.2 cm., and the doses increase to 4 c.c.; eight or ten injections complete the course. The vaccine seems to be specific: it produces in chronic cases the symptoms of acute encephalitis. Herpes appears on the face usually on the third day. Three patients in the acute and one in the subacute stage recovered. One out of three chronic cases treated lately presents a notable amelioration. The fever reaction is severe. The activity of the vaccine is limited to two or three weeks.

Nederlandsch Tijdschrift v. Geneeskunde, Amsterdam

1: 1397-1496 (March 28) 1925

*Roentgen-Ray Treatment of Granuloma. D. J. Steenhuis.—p. 1398.
Wassermann's Reaction in Active Tuberculosis. Vos.—p. 1412.
Unna's Treatment of Leprosy. Levy.—p. 1422.
Variations of the Sinuses of the Dura. C. van Gelderen.—p. 1427.
*Myogenous False Angina Pectoris. M. W. Scheltema.—p. 1432.
Provisions for Care of the Insane by the State. Beyerman.—p. 1456.

Roentgen-Ray Treatment of Malignant Granuloma.—Steenhuis relates that two of his twelve patients thus treated seem to be clinically cured, with earning capacity fully restored, one for two years to date. Two others were apparently cured but one is now under treatment for a recurrence. Six others were much improved but have succumbed since to recurrence, as also the first two cases in which the treatment was entirely inadequate. He declares that it is necessary to irradiate as promptly and as extensively as possible; fever need not be feared, the temperature tends rather to drop.

Myogenous Pseudo-Angina Pectoris.—The man's attack of pains suggesting angina pectoris and distress had lasted for two hours but the reflexes were normal and the eosinophils numbered 7 per cent. The day before there had been rheumatic pains in nearly all the muscles, and after a warm bath he had poured a pitcher of cold water over his chest as usual. Under bed rest and salicylate this myogenous pseudostenocardia soon subsided.

Acta Chirurgica Scandinavica, Stockholm

59: 1-90 (March 21) 1925

*Bone Cysts and Giant-Cell Tumors. A. Krogius.—p. 1.
Primary Actinomycosis in Breast. F. Langenskiöld.—p. 23.
Mesenteric and Retroperitoneal Lymphangiomas. A. Westman.—p. 37.
*Embolectomy. Aleman.—p. 50. Idem. Lundblad.—p. 68.
Retroperitoneal Rupture of Duodenum. C. Sandahl.—p. 55.
Surgical Treatment of Gastric Ulcer. A. Eiselsberg.—p. 71.
*Physiologic Conditions for Colostomy. A. Jirásek—p. 84.

Bone Cysts and Giant-Cell Tumors.—Krogius' case of fibrous osteitis in the left femur in a man, aged 45, had gradually developed after a severe trauma five years earlier. Examination twenty months after removal of the tumor and scraping of the walls of the bone cavity revealed a noteworthy reduction of the cavity and proliferation of bone tissue. From this instance and others on record, he concludes that the tumors designated as "benign myelogenous sarcomas with giant cells" have not been true sarcomas, but merely lesions of fibrous osteitis.

Two Cases of Embolectomy.—Aleman's embolectomy in a young man with heart disease, twenty-four hours after the first symptoms, resulted in complete restoration of the circulation. The occluding embolus, 3 cm. long, was lodged in the right femoral artery at the origin of the profunda. In Lundblad's case the embolus and thrombus in the common iliac artery were washed out by the gush of blood after a semiflexible probe had been worked up and down in the artery to loosen them.

Physiologic Conditions for Colostomy.—Persisting discomfort after colostomy in cases of inoperable tumors is generally due, Jirásek says, to a reflex spastic constipation, frequently affecting the entire alimentary canal. The colostomy should be a mechanical aid, and also eliminate the irritating reflex action of the tumor on the rest of the alimentary canal. It must be made immediately above the tumor, with complete severing of the intestine. He illustrates the necessity for this by three instances of colostomy for cancer in which the clinical picture, roentgen examination, and antispasm treatment showed the disturbances to be due to spasms of the alimentary tract above the colostomy.

Hygiea, Stockholm

87: 161-208 (March 15) 1925

Group Agglutination in Medicolegal Practice. Lindberger.—p. 164.
Intraspinal Treatment of Syphilis. Müllern-Aspegren.—p. 176.

Ugeskrift for Læger, Copenhagen

87: 47-68 (Jan. 15) 1925

Experimental Gynandromorphinsm in Fowls. Pézard et al.—p. 47.
Paroxysmal Hemoglobinuria. A. Nyfeldt.—p. 51.
Drop in Blood Pressure Under Sanocrysin. E. Sylvest.—p. 53.
The Sciatica Question. Faber.—p. 54. Idem. Jansen.—p. 55.
*Birth Control. J. Kuhn.—p. 58.

Attitude of the Profession to Birth Control.—This signed editorial states that each physician will of course have his own views on this subject from his own sociologic and ethical standpoint, but that all are agreed on the dangers of certain preventive measures, and also that there may be medical indications for prevention of conception, and that measures to prevent conception belong in the province of medicine. The family physician is the natural guide, counselor, and friend. He has nothing to do with the moral aspect of birth control, but the economic, the sociologic aspects may belong in the province of medicine. Kuhn urges physicians to take a decided stand in the matter, and not sidestep it as in the past, leaving the women to unscrupulous and dangerous hands already organizing to grasp them. He says: "We are confronting now the beginning of a disastrous development which the medical profession still can arrest."

87: 69-94 (Jan. 22) 1925

*Treatment of Rickets. A. H. Meyer.—p. 69.
History of Cocain in Ophthalmology. J. W. S. Johnsson.—p. 77.
Finer Needle for Lumbar Puncture. N. Antoni.—p. 78.
Spinal Fluid in Sciatica. Helweg.—p. 78. Idem. Neel.—p. 81.
Measures to Prevent Conception. J. Næser.—p. 86.
Segregation Versus Sterilization of the Unfit. Lemming.—p. 88.

Present Status of Treatment of Rickets.—Meyer remarks in conclusion that the research of the last five years has not decided the whole rickets question. There is much evidence which testifies that rickets is a collective term which includes affections of different etiology and pathogenesis. But the treatment now stands on a solid basis.

87: 95-116 (Jan. 29) 1925

*Heart Disease Complicating Pregnancy. K. Bierring.—p. 95.
*Prognosis of Congenital Syphilis. Lenstrup.—p. 104.
*The Sciatica Question. J. Helweg.—p. 106.
Scarcity of Physicians for State Hospitals for the Insane. Schröder.—p. 111.
Hunting Accidents. K. Lunn.—p. 112.

Heart Disease and Pregnancy.—Bierring has had eighty-seven obstetric patients with complicating heart disease, a total of 107 childbirths. Only eleven of the women developed severe heart symptoms, fatal in six and these were all elderly multiparas. Fully 50 per cent. passed through the pregnancy without symptoms. Five of the women had recurrence of acute articular rheumatism during the pregnancy, fatal in one. That failing compensation predisposes to spontaneous interruption of the pregnancy, was confirmed by eleven cases of abortion. From the total 107 pregnancies, there were ninety-eight viable children. Hence heart disease in the mother evidently does not affect the viability of the child. The women must be kept in bed for full three weeks after delivery.

Congenital Syphilis.—Lenstrup relates that 22 have died of the 167 children with congenital syphilis brought up in the Welander Home at Copenhagen; 37 seem entirely healthy and intelligent, 13 are imbecile and 28 mentally backward. The effect of treatment of the mothers during the pregnancy was very evident in the children.

The Sciatica Question.—Helweg answers here a number of protests against his muscular theory of sciatica.

87: 165-212 (Feb. 19) 1925

*Simplified Kidney Test. A. Norgaard.—p. 165.
*Carbohydrate Metabolism. Lundsgaard and Holbøll.—p. 168.
Measurement of Blood Pressure. C. Christensen.—p. 175.
Tardy Forms of Epidemic Encephalitis. V. Christiansen.—p. 179.
Roentgen Findings with Papillomas in Peritoneum. Nielsen.—p. 193.
The Pseudo-Plague Bacillus. M. Claudius.—p. 194.
Present Status of Care of the Insane. Daniel.—p. 201. Conc'n, p. 229.

Simplified Diuresis Test.—Norgaard allows the patient to drink at will till 9 p. m., but after this nothing is allowed. The next morning the patient drinks a liter of water at 6.30, and the urine is collected on the stroke of the hour thereafter for four hours. The patient stays in bed throughout this four hour course. In the four hours, and without preliminary deprival of water, this test reveals with precision the power of diuresis possessed by the kidney.

Carbohydrate Metabolism.—In this second report on their intensive study of carbohydrate metabolism, Lundsgaard and Holbøll present evidence that the specific rotation of light by a solution of alpha and beta glucose, after addition of fresh muscle tissue and insulin is due to the production of a new form of glucose with low specific rotating power. This glucose may be of the gamma type, but more probably is still another form. They explain it as the first phase of carbohydrate metabolism, calling it the ny (new) glucose.